Nutritional Coaching

Congratulations and welcome! You're about to embark on a journey of health and nutrition and we honored you've chosen us to be your guide! We look forward to working with you in helping you to achieve your wellness goals.

The following guidelines have been established to facilitate our work together. Please feel free to comment or ask any questions. We are here to meet your needs and offer optimal guidance.

After reviewing the office guidelines below, please initial, sign, and return prior to your initial session. If you have any questions please don't hesitate to ask.

Confidentiality

Our sessions are held in strict confidence. A release form will be used to speak to other health practitioners or other members of the treatment team should the need arise.

Initial here_____.

Session Times

Sessions are normally 45 minutes, but this may vary depending on progress and consultation options.

Initial here_____.

Cancellations

If you need to reschedule or cancel a session, simply leave a message on my voicemail (XXX-XXX-XXXX) or email (xxx@xxxx.com) at least 24 hours in advance of the scheduled session to avoid being charged for it.

Initial here_____.

Communicating Between Sessions

You are welcome to leave a phone message or send me an email at any time. I will respond at my earliest opportunity.

Initial here_____.

Health History & Questionnaire

Name & Information

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

General Information

Please check off any of the following that pertain to you (past or present) and **circle those that currently pertain to you**.

- ❒ Acne
- ❒ Addiction (alcohol, drugs)
- ❒ Anemia
- ❒ Anorexia
- ❒ Anxiety or Nervousness
- ❒ Arthritis
- ❒ Bladder Infections
- ❒ Bloating, Gas, or Indigestion
- ❒ Blood Sugar Problems
- ❒ Bronchitis
- ❒ Cancer
- ❒ Colds or Flu (frequent)
- ❒ Cold Sores
- ❒ Chronic Fatigue
- ❒ Constipation
- ❒ Dandruff
- ❒ Depression
- ❒ Diabetes I
- ❒ Diabetes II
- ❒ Difficulty Losing Weight
- ❒ Dry Skin
- ❒ Emotional Problems
- ❒ Emphysema
- ❒ Fainting
- ❒ Gall Bladder Problems
- ❒ Gout
- ❒ Hair Loss or Poor Hair Growth
- ❒ Headaches
- ❒ Heart Disease or Problems
- ❒ Heartburn
- ❒ Hemorrhoids
- ❒ Herpes
- ❒ High Blood Pressure

- ❒ High Cholesterol
- ❒ HIV or AIDS
- ❒ Hot Flashes
- ❒ Hypoglycemia
- ❒ Insomnia
- ❒ Kidney Stones or Other Issues
- ❒ Liver Problems
- ❒ Loose Stools
- ❒ Memory Loss or Confusion
- ❒ Nails, Poor Growth or Brittle
- ❒ Panic Attacks
- ❒ Parasites
- ❒ Pregnant or Nursing
- ❒ Respiratory Problems
- ❒ Ringing in Ears
- ❒ Seizures
- ❒ Severe Mood Swings
- ❒ Skin Conditions
- ❒ Stroke
- ❒ Suicidal Tendencies
- ❒ Thyroid Condition
- ❒ Ulcer
- ❒ Yeast Infections

Other: _____

_____

_____

_____

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____

_____

_____

_____

Eating Habits And Lifestyle

How would you generally describe your eating habits? _____ Good _____ Fair _____ Poor
How many times a day do you eat? _____ How long does it take you to complete a meal? _____
When you chew your food, do you _____ take your time? _____ chew a few times then swallow?
Do you use a straw to drink beverages? Yes / No Do you chew gum? Yes / No How often? _____
Number of carbonated beverages daily ____
Number of caffeine beverages daily (coffee, regular colas, teas ____
How much water do you drink daily? _____
Do you smoke? ____ Drink alcohol? _____ How much and when?
_____

Do you take any recreational drugs? Yes / No If yes, please list below:
_____
_____

Do you take any vitamin/mineral supplements? Yes / No If yes, please list below:
_____
_____

Do you currently take any medication Yes / No If yes, please list below:
_____
_____

Do you have any food allergies, restrictions, or sensitivities? Yes / No If yes, please list below:

_____

_____

What is your relationship status? _____ Children? _____

Occupation: _____ How many hours per week do you work?

_____

Do you sleep well? _____ How many hours per night?

_____

Reason for seeking nutritional counseling: _____

What goals do you hope to receive as a result of nutritional counseling?

_____

_____

Weight History

Current weight _____ Weight six months ago? _____ One year ago?

_____

Would you like your weight to be different? _____ In what way?

_____

Please complete the following concerning any diets you have attempted:

Name/Type of Diet	Weight Change (+/-) in	How long did the weight change last?

Have you ever used laxatives for weight control? Yes / No

Have you ever vomited for weight control? Yes / No

Exercise History

Which of the following primarily describes your work or daily activity?

____ Sitting ____ Standing ____ Walking or other active motion

____ Heavy Labor (such as heavy lifting)

Do you exercise? _____ If yes, how often? _____

_____

Do you ever exercise compulsively? _____ If yes, how often?

_____

Toxin Analysis

Do you or have you ever had silver fillings? _____ How many? _____ Have they been removed? _____

Do you use environmentally friendly household products? _____

Do you eat primarily organic foods? _____

Stress and Energy Assessment

Is your daily stress level: ____ Very High ____ High ____ Moderate ____ Low

Do you feel anxious? _____ If so, how often? _____

How many hours do you sleep each night? _____ Is it a restful sleep?_____

Describe your energy levels throughout the day

_____

Do you suffer from headaches? _____ If so, how often?

_____

Do you follow a regular awareness program? (prayer, meditation, etc.)

_____

Digestive and Colon Health

How often do you experience the following? (1 – Seldom, 2 = Often, 3 = Always)

	1	2	3		1	2	3
Irritable if meals are missed				Slow to get started in morning			
Feel shaky or have jitters				Salt cravings			
Need coffee to start day				Dizzy when stand up quickly			
Easily irritated				Afternoon fatigue			
Sugar cravings during day				Afternoon headaches			
Fatigue fades when you eat							
Poor memory or forgetful				Gain weight easily			
				Experience cold hands and feet			
Want to nap after eating				Thinning of hair			
Sugar cravings after meals				Waking with a headache			
Increased appetite or thirst				Require excessive amounts of sleep			
Frequent urination				Dry skin or scalp			
Difficulty losing weight				Mental fog or sluggishness			
Experience 3pm slump				Tired frequently			
Difficulty falling asleep							
Gain weight easily when stressed							
Wake up tired after full nights sleep							
Excessive sweating							

How many bowel movements do you have each day? _____

Have you ever tried a colon cleansing program? _____ If yes, which one(s)?

_____

_____

Do you use laxatives frequently? _____ If yes, explain

_____

Do you have any of the following conditions:

____ Irritable Bowel Syndrome (IBS)
____ Constipation
____ Diarrhea
____ Diverticulosis or Diverticulitis
____ Bowel Obstruction
____ Hemorrhoids
____ Gas
____ Bloating
____ Blemishes or Acne
____ Candida

In the past year, have you taken antibiotics? _____ If so, when and for how long?

_____

How often do you experience the following? (1 – Seldom, 2 = Often, 3 = Always)

	1	2	3		1	2	3
Gassy following a meal				Yellowish eyes or skin			
Difficulty digesting plants				Gas/bloating 1-2 hours after meals			
Bad breath				Itchy skin			
Excessive burping				Greasy food causes distress			
Constipation after eating				Bitter, metallic taste in mouth			
Excess gas							
Indigestion 1-2 hours after meals				Feeling hungry 1-2 hours after meals			
Mucous-like, greasy stools				Stomach pain after eating			
Difficulty losing weight				Heartburn			
Nausea and/or vomiting				Bloating			
Pain on left side							

Men's Health

How often do you experience the following? (1 – Seldom, 2 = Often, 3 = Always)

	1	2	3		1	2	3
Difficulty urinating or dribbling				Less full erections			
Frequent urination				Loss of morning erections			
Painful ejaculation				Unexplained weight gain			
Blood in urine				Sore muscles			
				Mental fatigue			
Decrease in libido				Inability to concentrate			
Inability to put on muscle				Increased fat around hips and chest			
Decreased erections				Mood swings			

Women's Health

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? _____ Heavy or light flow?_____

Are you currently using birth control? _____ If yes, what kind? _____

For how long? _____ Is this something you wish to continue doing? _____

Are you menopausal? _____ If yes, how long? _____

Have you experienced facial hair growth? _____ If yes, how long? _____

	Generally	PMS	Menses		Yes	No
Bloating				Feel cold often?		
Breasts Tender				Dislike the cold?		
Cramping				Feel hot often?		
Moodiness/Irritable				Dislike the heat?		
Depression				Daytime sweats?		
Anxiety				Nighttime sweats?		
Highly emotional				Sweaty palms or soles of feet?		
Fuzzy thinking/lack focus				Cold hands or feet?		
Headaches				Small but frequent thirst?		
Dizzy				Big thirst?		
Water retention				Frequent urination?		
Acne/Skin eruption						
Dry Skin						
Loss of libido?						

Food Assessment

Is your diet mostly cooked, raw or a combination?

Please circle if you eat the following. Place an "O" next to the word for often, or "S" for sometimes:

Beef	Cow Milk	Pastries/ cookies/ candy
Chicken	Goat milk products	Margarine/Shortening
Pork	Cheese	Fried foods
Eggs	Butter	Yogurt or ice cream
Fish	Sushi or raw meat	Nut butters/Tahini
Brown or White Rice	Wheat bread	Beans
Amaranth	White pasta or Wheat pasta	Tofu or Tempeh
Millet	Buckwheat	Miso
Quinoa	Oats	Nuts and/or seeds

Please list veggies you usually eat:

Fruits:

What foods can you absolutely not tolerate?_____
What percentage of your food is prepared at home? _____
Where does the remainder come from? _____

Other Important Information

Please list your chief health concerns that you would like to improve.

1_____

2 _____

3 _____

Please list any other health concerns or areas you would like to improve:

_____

_____

_____

By signing below, you acknowledge that any dietary or supplemental suggestions made by YOUR NAME
are entirely educational in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

Signed: _____ Date: _____

Agreement & Release

I, _____, the undersigned, do hereby acknowledge that YOUR NAME states to me the she is an educator and a holistic health counselor and that she is not a licensed medical doctor or licensed primary care provider.

I understand YOUR NAME'S sole intention is to offer me the general educational information I request. If I choose to use this information to work on myself then I affirm that the responsibility is solely mine.

I understand YOUR NAME to state one should never use HIS/HER information in any way that contradicts, conflicts, or opposes a course of treatment recommended by a primary health provider such as a licensed medical doctor. If I ever perceive or feel that information given by YOUR NAME opposes a licensed doctor's treatment or recommendations, YOUR NAME strongly advises me to follow the advice and instructions of my licensed primary health care provider.

In consideration of my participation in Transformational Nutrition Coaching, I hereby accept all risk to my health and of my injury or death that may result from such participation and I hereby release the above named individual, its governing board, officers, employees and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation in Transformational Nutrition Coaching, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described in Transformational Nutrition Coaching session.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR MY INJURY OR DEATH OR DAMAGE TO MY PROPERTY THAT OCCURS WHILE PARTICIPATING IN NUTRITION AND WELLNESS COUNSELING AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY MY NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

I, the undersigned, do hereby voluntarily state to understand and acknowledge as accurate all the above comments.

Signature: _____ Date: _____

Printed Name: _____

Address: _____

Telephone: (home) _____ (work) _____ (cell) _____