Nutrition Services

Client Confidentiality Agreement:

I,_____, take full responsibility for my health, progress and healing on my nutrition plan. I acknowledge that changes in health take time and I am ready for a plan that is not about quick fixes but rather about smaller changes over a period of time that lead to sustainable change.

All information shared within this professional relationship will be held in strict confidence. Information may be shared at the client's request with a medical doctor, naturopathic physician or any other healthcare practitioner the client deems to be appropriate.

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine.

Date: _____

Signature: _____

Name: _____

(please print)

Signature of Nutritionist: _____

Name: Ashley Ann Anderson B.Sc (Hons), CNP, NNCP

Date: _____

Initial Intake Forms:

Thank you and thank yourself for investing in your holistic nutrition and health! Please note that all information is kept strictly confidential and will not be shared with third parties. Please be as candid and open as possible to get the most out of your session. Use extra sheets of paper if necessary.

Client Information:

Full Name: _____

Primary phone: _____ Email: _____

Date of birth: _____ Marital status: _____

Do you have any children? If yes, how many and what ages?

_____

Address: _____

City: _____ Province: _____

Postal code: _____ Country: _____

Main Health Concerns:

Please answer each of the following questions to the best of your ability. You may skip questions that do not pertain to your health concern(s).

List your main health concerns (i.e. digestion, weight, skin issues, fatigue, headaches, etc.) Please list in priority:

_____

_____

_____

Age: _____

Height: _____

Weight: _____

At what weight did you FEEL your healthiest?

_____

Date: _____

Body Type (see diagram) : _____

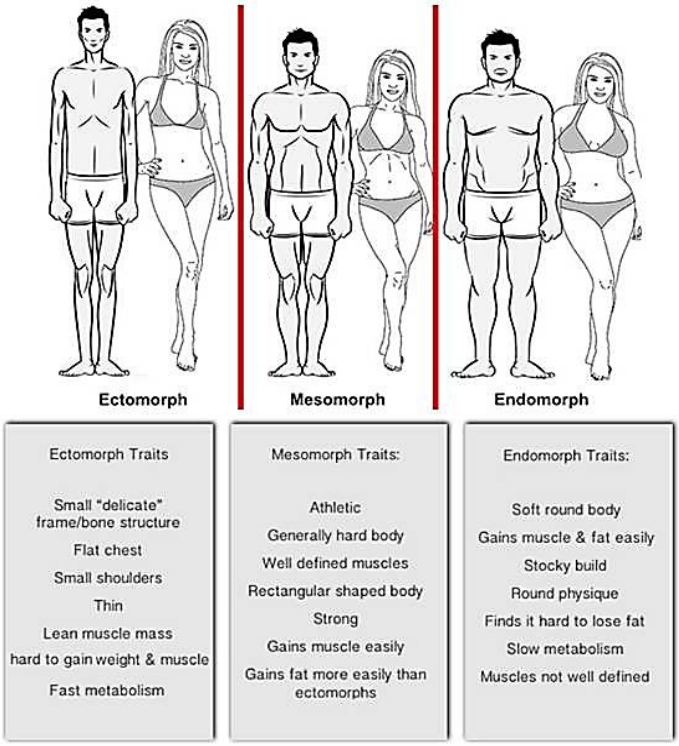
Blood Type: _____

Resting Pulse rate: _____

Blood Pressure: _____

Waist circumference (at belly button): _____

Hip circumference (over widest part): _____



You may electronically submit completed forms to: Momentum Healing Arts Centre: info@momentumhealingarts.com or Ashley Anderson (Nutritionist): ashley.ann.anderson@gmail.com

Fasting glucose level: _____

Fasting urine pH: _____

Fasting saliva pH: _____

Personal Health History:

Have you ever received a diagnosis for a health concern or illness (as far back as childhood)? Yes No

If yes, please explain: _____
_____

Are you seeking treatment from any other health care practitioners? Please list *(i.e. Medical doctor, Medical Specialist (s), Naturopath, Chiropractor, Osteopath, Acupuncturist/ TCM doctor, Psychologist, Herbalist):*

_____
_____

Do you provide consent for Ashley Anderson (your nutritionist) to communicate with any or all other health care practitioners on matters relating directly to your health in order to provide the absolute best complementary health and nutrition care? Yes No

If yes, please provide contact information:

Health care practitioner:	Specialty:	Contact information:
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications you are currently taking, along with the reason for use, and dosage:

Medication:	Reason:	Dosage/duration:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken antibiotics over the past five years? _____
Please describe your antibiotic use:

_____
_____

List any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages. Please include the brand:

Supplement:	Reason:	Dosage/duration:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____
_____ _____ _____

_____ _____ _____
_____ _____ _____

List your family history (grandparents, parents, siblings) of health issues (high blood pressure, diabetes, cancer, etc):

_____
_____
_____

Please indicate any symptoms you are currently experiencing:

_____
_____
_____

List any known allergies (food, environmental, medications) and/or suspected food sensitivities:

_____
_____

Do you have any silver-mercury fillings? Yes No

Have you ever been hospitalized? Yes No

If yes, for what reason? _____
_____

Have you had surgery to remove your: gall bladder? appendix? Intestine? tonsils? Any other? If so, when?

_____

Digestive Health:

How often do you have a bowel movement? _____
Do you strain to have a bowel movement? Yes No Occasionally

If yes, is it related to a particular food, stress or circumstance? _____

Do you have loose bowel movements? Yes No Occasionally

If yes, is it related to a particular food or circumstance? _____

Circle/indicate any other digestive concerns:

Bloating Gas Cramping Diarrhea Heartburn Indigestion

other: _____

Emotional Health History:

Has there been any significant emotional trauma in your life (divorce, loss of a loved one, accident, abuse)? Please describe:

_____

On a scale of 1-10 (1 being lowest), how would you describe your:

Stress levels _____

Energy levels _____

Happiness _____

What are the major causes or factors of your stress? _____
_____

How does your stress manifest itself (i.e. fatigue, irritability, anxiety, panic attacks, lightheadedness)?

_____
_____

What coping mechanisms do you use? _____
_____

Are all of your relationships happy and fulfilling? _____
Do you ever eat for emotional reasons? _____
Do you, or have you ever had an eating disorder? Please explain: _____
_____

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day?

_____

How many hours on average do you sleep daily? (Include naps) _____
What time do you go to sleep? _____ Awaken? _____

Do you have trouble: falling asleep? staying asleep? Yes No Occasionally

Do you awaken feeling rested? Yes No

What do you do for exercise? (Indicate type, frequency, time of day and duration)

_____
_____

What is your occupation? _____
Do you enjoy your work? Yes No Sometimes

How many hours each day do you work? _____

At what times do you start and end work? _____
Do you do work shifts or are you on a regular schedule? _____
How many hours do you spend daily, on average:

Driving _____ Watching television _____ Reading _____ In front of computer _____

What are your interests and hobbies? _____
Do you have time for them? _____

Do you vacation regularly? Yes No

When was your last vacation? _____

Please indicate your religion/personal philosophy: _____

Do you consume alcohol? Yes No If yes, how much and how often? _____

Do you smoke? Yes No If yes, how much and how often? _____

Do you use recreational drugs? Yes No If yes, how much and how often? _____

Have you ever been treated for drug and/or alcohol dependency? Yes No

If yes, please describe: _____

Reproductive Health History:

Do you have a healthy sex drive? If not, when was the last time you remember having one?

_____

Do you have any hormonal issues that you know of? Please explain if so:

_____

Females only:

Please circle any symptoms of PMS you experience:

Cramping Bloating Headaches Mood changes Breast tenderness Irritability

Please circle any symptoms of Menopause you experience:

Hot flashes Cravings Headaches Mood changes Weight Gain Irritability

Do you experience emotional upset consistently every month? If so, please describe (anxiety, depression, etc):

_____

_____

How often do you have a menstrual cycle? _____

Are you on birth control? If yes, for how long? _____

Are you using hormone replacement? If so, synthetic or natural, what type, and for how long?

_____

Have you given birth? If yes, how many times? _____

Have you had a miscarriage? If yes, how many? _____

Have you had an abortion? If yes, how many? _____

Have you had any fertility treatments? If yes, please describe: _____

Are you or could you be pregnant? Yes No

Have you noticed any changes in your menses, for example, in the frequency, duration, flow, clotting, etc.? Please specify: _____

Have you had a bone density test? Yes No

If yes, what was the result? _____

Dietary Health History:

How many times a day do you eat?

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

How do you eat meals? *(circle all that apply)*

With family With friends Home alone On the run At a restaurant Fast food/ Drive Thru

While watching TV, Computer, On Phone At Work Desk while working In Car

Do you feel there are restrictions to your diet due to preferences of others (family, roommates, etc)? Yes No

If yes, please explain: _____

_____

How many servings of each of the following do you typically eat in a day?

(ex: 1 serving = 1 cup or fist full of fruit or vegetable; ½ cup cooked grains lentils beans or pasta; 1 slice of bread; thumb size of cheese; 250ml of milk, 125ml of juice; 1oz of nuts or seeds; 1 tablespoon of oil or butter; ¼ avocado,; palm size of animal protein, ¾ cup yogurt or cottage cheese)

Fruit: ____

Fresh ____ Dried ____ Canned ____ Frozen ____

Vegetables: ____

Cooked ____ Raw ____ Canned ____ Frozen ____

Grains: ____

Whole ____ Refined ____

Protein:

Type _____ ____

Dairy Products:

Type _____ ____

Fats:

Type _____ ____

Other: Specify _____

Do you eat organic foods? If so, what foods and how often: _____

_____

Do you eat the following foods? Please check all of the following foods that you have eaten in the past 30 days:

❒ **Vegetables**
❒ Asparagus
❒ Avocados
❒ Beet greens
❒ Beets
❒ Bell peppers
❒ Bok choy
❒ Broccoli
❒ Brussels sprouts
❒ Cabbage
❒ Carrots
❒ Cauliflower
❒ Celery
❒ Collard greens
❒ Corn
❒ Cucumbers
❒ Eggplant
❒ Fennel
❒ Garlic
❒ Green beans
❒ Green peas
❒ Kale
❒ Leeks
❒ Mushrooms, crimini
❒ Mushrooms, shiitake
❒ Mustard greens
❒ Olive oil, extra virgin
❒ Olives
❒ Onions
❒ Potatoes
❒ Romaine lettuce
❒ Sea vegetables
❒ Spinach
❒ Squash, summer
❒ Squash, winter
❒ Sweet potatoes
❒ Swiss chard
❒ Tomatoes
❒ Turnip greens

❒ **Fruits**
❒ Apples
❒ Apricots
❒ Bananas
❒ Blueberries
❒ Cantaloupe
❒ Cranberries
❒ Figs
❒ Grapefruit
❒ Grapes
❒ Kiwifruit
❒ Lemon/Limes
❒ Oranges
❒ Papaya
❒ Pears
❒ Pineapple
❒ Plums & Prunes
❒ Raspberries
❒ Strawberries
❒ Watermelon

❒ **Seafood**
❒ Cod
❒ Salmon
❒ Sardines
❒ Scallops
❒ Shrimp
❒ Tuna

❒ **Nuts & Seeds**
❒ Almonds
❒ Cashews
❒ Flaxseeds
❒ Peanuts
❒ Pumpkin seeds
❒ Sesame seeds
❒ Sunflower seeds
❒ Walnuts

❒ **Beans & Legumes**
❒ Black beans
❒ Dried peas
❒ Garbanzo beans (chickpeas)
❒ Kidney beans
❒ Lentils
❒ Lima beans
❒ Miso
❒ Navy beans
❒ Pinto beans
❒ Soy sauce
❒ Soybeans
❒ Tempeh
❒ Tofu

❒ **Poultry & Meats**
❒ Beef, grass-fed
❒ Chicken, pasture-raised
❒ Lamb, grass-fed
❒ Turkey, pasture-raised

❒ **Eggs & Dairy**
❒ Cheese, grass-fed
❒ Cow's milk, grass-fed
❒ Eggs, pasture-raised
❒ Yogurt, grass-fed

❒ **Grains**
❒ Barley
❒ Brown rice
❒ Buckwheat
❒ Millet
❒ Oats
❒ Quinoa
❒ Rye
❒ Whole wheat

❒ **Herbs & Spices**
❒ Basil
❒ Black pepper
❒ Chili pepper, dried
❒ Cilantro & Coriander seeds
❒ Cinnamon, ground
❒ Cloves
❒ Cumin seeds
❒ Dill
❒ Ginger
❒ Mustard seeds
❒ Oregano
❒ Parsley
❒ Peppermint
❒ Rosemary
❒ Sage
❒ Thyme
❒ Turmeric

Please indicate if you eat or use the following: **(indicate "1" for "rarely", "2" for "regularly", "3" for "often")**

Aluminum pans ____	Fried foods _____	Nutra Sweet/Aspartame _____
Margarine _____	Refined foods _____	Tuna/ Large fish ____
Candy _____	Luncheon meats ____	Cell phone _____
Microwave ____	Fast foods _____	Antiperspirant _____

Please indicate how many cups (250ml) of the following do you drink per week (Sunday to Saturday):

Coffee (black): _____	Cream (10%, 18% or +): _____	Fresh vegetable juices: _____
Tea (caffeinated) ____	Soft drinks (diet) _____	Fruit juices (prepared/ from concentrate) _____
Herbal tea _____	Soft drinks (regular) _____	Water _____
Milk (skim or 1%) _____	Fresh fruit juices (not from concentrate) _____	Other_____
Milk (2% or homo) ____		

What is the source of your water (i.e. tap, filtered, bottled, carbonated)? _____

Do you have any dietary restrictions? (vegan, vegetarian, no dairy, etc). Please explain and list all:

_____

_____ _____

How often do you eat meat? Daily 3-5/week Once/week or less Never

How often do you consume dairy products? Daily 3-5/week Once/week or less Never

What are your favorite foods and/or cravings? _____

_____

Are there any foods you feel addicted to? _____

How often do you eat them? _____

What foods do you eat most often (list top five): _____

_____

Do you avoid certain foods? If so,why? _____

_____

Are there any foods you are not willing to give up? _____

Describe your relationship with food (excellent, good, poor, food is your enemy). Be specific:

_____

Do you experience any symptoms if meals are missed? Explain: _____

_____

Do you experience any symptoms after meals? Explain: _____

_____

Your Nutritional Future:

Please describe your expectations from your nutrition program:

First and second visit:

_____

_____

Long term: _____

_____

Do you wish to gain weight? Lose weight? How much? _____

By when do you wish to reach your goal weight? _____

What is your main motivation to change your weight? _____

_____

When, if ever, were you last at your 'ideal' weight?

_____

Have you tried weight loss programs in the past (if so, please describe)?

_____

_____

What were the results?

_____

_____

What did you like/dislike about the program(s)?

_____

_____

What is your level of commitment to addressing underlying causes of your signs and symptoms? (0 – 10) _____

10 being 100% committed and willing to change nutrition, exercise and lifestyle,
8 = willing to change most nutrition, exercise and lifestyle,
6 = willing to change some nutrition, exercise and lifestyle,
4 = willing to change at a minimal amount or at a slow pace,
1 = I'm not ready to make any changes yet but want to learn what I can do)

Do you have any family, friends, coworkers, or peers that can support you and keep you accountable? Yes No

If yes, who? List all _____

Thank you for taking the time to complete this form! I look forward to working with you to achieve better health!

You may electronically submit completed forms to: Momentum Healing Arts Centre: info@momentumhealingarts.com or Ashley Anderson (Nutritionist): ashley.ann.anderson@gmail.com

Before your appointment:

Please bring completed forms with you to your appointment or email them before your appointment.

Please also bring any additional and relevant test results from: blood tests, urine/ fecal/colonoscopy tests, saliva hormone tests, live cell microscopy tests, food and allergy tests, sleep clinic tests, bone density scan, medical diagnostic imaging and/or x-rays, biopsy, or any additional test results.

LET'S GO GREEN! (environmentally conscious)

You may electronically submit completed forms to:

Attention: Nutritionist

Momentum Healing Arts Centre: info@momentumhealingarts.com and/or
Ashley Anderson (Nutritionist): ashley.ann.anderson@gmail.com