Roots Up Nutritional Consulting
for your nutritional needs from the roots up

CLIENT INTAKE FORM

(all questions are optional)

DATE: _____

NAME: _____ BIRTHDATE:_____

ADDRESS: _____

City/Province: _____ Postal Code: _____

PHONE: (home) _____ (cell) _____

EMAIL: _____

SINGLE/PARTNER/MARRIED: _____

CHILDREN: _____

OCCUPATION: _____

EMERGENCY CONTACT: _____

(relationship): _____

HOW DID YOU HEAR ABOUT ROOTS UP NUTRITIONAL CONSULTING?

_____

Client Statement:

I understand and acknowledge that the services hereby 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. This statement is being signed voluntarily.

Date: _____

Signature: _____

Name (please print): _____

REASON FOR NUTRITIONAL CONSULTATION:

List the symptoms or conditions you would like improved or treated in this consultation:

_____

_____

_____

CURRENT HEALTH HISTORY:

Have you ever been diagnosed by a Doctor with any of the following?

Check any that apply:

- ☐ Diabetes
- ☐ GI disorders
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Anaemia
- ☐ Asthma
- ☐ Kidney or liver disease
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Other _____

Give details and symptoms of the above conditions (when were you diagnosed, frequency, what makes your symptoms better or worse, treatments and were they successful?):

_____

_____

What medical tests or investigations have you had recently? (Include reason and results):

_____

Do you have low iron levels? (When were you tested?):

_____

Do you take medications, either prescribed or over-the-counter?
Name of drug/reason for taking/dose frequency/duration of intake:

_____

_____

_____

Do you have any allergies? If so, please list:

_____

_____

Which vitamins or other nutritional supplements do you take regularly? (include dosages)

_____

_____

_____

Are you currently seeing any other health practitioners? (acupuncturist, chiropractor, physiotherapist, counsellor, etc.):

_____

_____

GENERAL HEALTH:

I feel that I have not felt well since.....(ex: a particular event, illness, loss, trauma):

How many times a year do you get a cold or flu?

How often do you take antibiotics? When was the last course taken?:

Do you suffer from any of the following:

- ☐ Twitching eye
- ☐ Poor memory
- ☐ Poor wound healing
- ☐ Muscular cramps (where?_____)
- ☐ Feeling faint
- ☐ Poor concentration
- ☐ Muscle weakness (where?_____)

Do you suffer from:

☐ Headaches? ☐ Migraines?

Describe symptoms of your headache or migraine (ex: frequency, duration, time of day, what makes them better or worse – foods/coffee/time day/stress, describe the pain and location):

ENERGY LEVELS:

On a scale of 1 to 10, indicate where your energy levels are currently:

(Low) ☐ 1 .... ☐ 2 .... ☐ 3 .... ☐ 4 .... ☐ 5 .... ☐ 6 .... ☐ 7 .... ☐ 8 .... ☐ 9 .... ☐ 10 (High)

Do you feel that you have an energy slump at a particular time of the day or night? Explain:

Do you feel tired or lethargic after eating?

How do you feel first thing in the morning?

SLEEP:

Do you feel that you are getting a good night sleep?

How many hours sleep a night do you get on average?

Do you have any problems getting to sleep?
(Explain: ex. worrying about things, mind won't switch off, stress, anxiety?):

Do you have any problems staying asleep?
(Explain: ex. need to go to the toilet, panic attack, baby wakes you, etc.):

Do you wake at any particular time? What time?

Do you suffer from sleep apnea?

Do you snore?

DIET DIARY:

Fill out the following diet diary in as much detail as possible.
(Include portions, beverages and roughly what time you eat each meal):

What do you eat and drink during a normal day?

Breakfast:

Mid-morning snacks:

Lunch:

Afternoon snack:

Dinner:

Dessert:

Before bed snack:

ADDITIONAL DIETARY INFORMATION:

Are you a: ☐ vegetarian or ☐ vegan

Do you crave any foods in particular?

List any other foods you eat regularly:

How much water do you have daily?

How many coffees do you have a day?

How many teas do you have a day? What type?:

How many juices do you have a day?
What type? ex. freshly squeezed, bottled, 100%, added sugar, or fruit drink:

Do you drink electrolyte sports drinks? What type and how often?

How much alcohol do you have weekly? What type?

Do you smoke cigarettes? How many a day?

Do you take recreational drugs? What type and how often?

Do you have problems eating any foods in particular?

List any foods you dislike and won't eat:

Do you have any of the following symptoms?

- ☐ often thirsty
- ☐ having trouble digesting fatty foods
- ☐ large appetite
- ☐ dry mouth
- ☐ small appetite
- ☐ always hungry

How many pieces of fruit do you eat a day?

Do you eat vegetables every day? _____

Grains?_____Dairy?_____Fish?_____Meat?_____

Do you add salt to your food?

Do you add sugar, artificial sweeteners or honey to meals or beverages?
What type and daily amount:

_____

Are you sensitive to:

- ☐ MSG
- ☐ caffeine
- ☐ garlic
- ☐ sugary foods_____)
- ☐ sulphites (wine, dried fruits)
- ☐ onion
- ☐ alcohol
- ☐ spicy foods

DIGESTIVE HEALTH:

Please indicate if you are suffering from any of the following:

- ☐ gluten intolerance (Celiac)
- ☐ wheat intolerance
- ☐ lactose intolerant
- ☐ milk protein allergy

Do you feel bloated after eating? List foods:

_____

_____

Do you get excessive flatulence after eating? List foods:

_____

_____

Do you burp often after eating? List foods:

_____

_____

Do you experience reflux, heartburn, or indigestion?
Explain symptoms, what makes it worse. Ex. after a particular food)

_____

_____

Do you experience abdominal pain or cramping?
Explain. Ex. after a particular food, location of pain or cramping)

_____

_____

Do you feel nauseous or vomit often?
What makes it worse or better?

How many times a day do you have a bowel movement?

Do you suffer from constipation?
Explain. Ex. how often, after eating certain foods, when stressed?

Do you have any pain or straining during bowel movements?

Do you suffer from diarrhoea?
Explain. How often, after eating certain foods, when stressed?

Do you suffer from alternating constipation and diarrhoea? Explain.

NAIL AND HAIR HEALTH:

Do you have any white spots on your nails?

Describe the health of your nails (weak, split easily, soft, brittle, fungal infection):

Do you have any problem with hair loss? Explain.

ORAL HEALTH:

Do you suffer from any of the following?

☐ cold sores	☐ ulcers	☐ dry lips
☐ bleeding gums	☐ teeth problems	☐ gingivitis
☐ bad breath	☐ cracked lips, corners	☐ cracked lips, centre
☐ grind teeth	☐ loss of taste & smell	☐ other _____

Give details and symptoms of the above conditions:
Ex. frequency, what makes symptoms worse – stress, when run down, etc.

_____

_____

EAR AND EYE HEALTH:

Do you suffer from any other following?

- ☐ recurrent ear infections
- ☐ tinnitus (ringing ears)
- ☐ hearing problems
- ☐ perforated ear drum
- ☐ other: _____

Give details and symptoms of the above condition:
Ex. frequency, what makes the symptoms worse – stress?

_____

Do you suffer form any of the following?

- ☐ glaucoma
- ☐ cataracts
- ☐ conjunctivitis
- ☐ styes
- ☐ red eyes
- ☐ itchy eyes
- ☐ dry eyes
- ☐ watery eyes
- ☐ dark circles around eyes
- ☐ other: _____

NOSE AND RESPIRATORY:

Do you suffer from any of the following?

- ☐ hay fever (allergic rhinitis -- seasonal or all year round?) _____
- ☐ recurring tonsillitis
- ☐ asthma
- ☐ sinusitis
- ☐ pneumonia
- ☐ bronchitis
- ☐ wheezing
- ☐ breathlessness on exertion
- ☐ frequent nose bleeds
- ☐ nasal polyps
- ☐ other: _____

Give details and symptoms of the conditions above:
Ex. frequency, causative factors, what makes it worse -- pollens/foods/animal hair/time of year?

_____

_____

CARDIOVASCULAR HEALTH:

Do you suffer from any of the following conditions?

- ☐ High blood pressure: what was your last reading and when _____
- ☐ Low blood pressure: what was your last reading and when? _____
- ☐ High cholesterol: what was your last reading and when? _____
- ☐ Chest pain
- ☐ heart palpitations
- ☐ bruise easily
- ☐ varicose veins
- ☐ cold hands and feet
- ☐ swollen feet or ankles
- ☐ palpitation on exertion

Are you generally a hot or cold person?

_____

Do you get fluid retention? where:

_____

Do you sweat excessively? where:

_____

Do you get night sweats?

_____

URINARY SYSTEM HEALTH:

Do you suffer from recurrent urinary tract infections?
Explain. (Ex. how often, symptoms, when was your last UTI, usual treatment?)

_____

Describe your urine:

- ☐ clear colour
- ☐ dark yellow colour
- ☐ offensive smell
- ☐ contains blood

DO you have any of the following symptoms?

- ☐ urinary incontinence
- ☐ frequent urination
- ☐ pain urinating
- ☐ difficulty urinating
- ☐ incomplete urination
- ☐ sudden urgency

Describe the above symptoms:

FEMALE REPRODUCTIVE HEALTH:

Do you take the contraceptive pill? How long have you been on the pill and which one?

Do you have a yeast infection/candida? How often do you get thrush? Describe symptoms:

Do you suffer from any of the following conditions?

- ☐ endometriosis
- ☐ fibroids
- ☐ polycystic ovaries
- ☐ polyps
- ☐ breast lumps

Give details and symptoms of the condition above (when it was diagnosed and treatments):

Do you have genital herpes? (how often do you get flare-ups?)

Do you have any other sexually transmitted diseases?
List - include symptoms and when did you contract the STD

PREGNANCY HEALTH:

Are you pregnant at the moment? How many weeks?

Is this your first pregnancy?

Have you had any problems with past pregnancies?
(Ex. miscarriage, gestational diabetes, ectopic pregnancy, pre-eclampsia)

Have you had any spotting? Explain.

Do you have any morning sickness? What makes it better or worse?

Do you have any of the following pregnancy related conditions?

☐ gestational diabetes ☐ pre-eclampsia

List any other symptoms with your pregnancy that you are concerned about:

POST-NATAL HEALTH:

Have you recently had a baby? When?

Did you have a vaginal delivery or Caesarean?

Are you currently breastfeeding, and if so have you had any difficulties?

Are you suffering from any of the following?

☐ mastitis ☐ sore, cracked nipples
☐ bleeding nipples ☐ breast abscess
☐ low milk supply ☐ blocked milk ducts
☐ nipple thrush ☐ breast red and hot
☐ pain when breast feeding ☐ other: _____

Describe the symptoms above in detail:

MENSTRUAL CYCLE:

Do you have regular periods? _____

How many days is your menstrual cycle? _____

How many days do you bleed for? _____

Do you get mid cycle bleeding? _____

Do you have heavy or light periods? _____

Do you get any clotting? _____

Do you have any of the following menstrual problems?

- ☐ absence of period
- ☐ irregular periods
- ☐ painful periods
- ☐ very heavy periods

Give details of the above condition:

_____

Do you suffer from any of the following PMS symptoms?

- ☐ sore breasts
- ☐ fluid retention
- ☐ cramping
- ☐ irritability
- ☐ mood swings
- ☐ depressed
- ☐ cry a lot
- ☐ sugar cravings
- ☐ other: _____

When do you get the above symptoms, before or during your period?

_____

Do you get period pain? (Before or during your period):

_____

What makes the pain better or worse?
(Ex. pressure, hot water bottle, crunching over, stretching back, lying down, etc.):

_____

When was your last pap smear and what was the result?

_____

MENOPAUSAL:

Are you:

- ☐ pre-menopausal
- ☐ menopausal

What was your last period?

_____

Are you on HRT or considering going on HRT?

_____

Explain your menopausal symptoms: (Ex. hot flushes, vaginal dryness, depression, dry skin)

_____

MALE REPRODUCTIVE HEALTH:

Do you have any problems with prostate health? Explain:

_____

Do you have genital herpes? (how often do you get flare-ups?)

_____

Do you have any other sexually transmitted diseases?
List - include symptoms and when did you contract the STD

_____

SKIN HEALTH:

Do you suffer form any of the following:

- ☐ eczema
- ☐ tinea
- ☐ warts
- ☐ dermatitis
- ☐ dandruff
- ☐ yellow skin
- ☐ acne
- ☐ white patches
- ☐ psoriasis
- ☐ itchy scalp
- ☐ skin cancer
- ☐ hives
- ☐ itchy skin on body
- ☐ small bumps on back of arms
- ☐ rash
- ☐ other: _____

Describe the symptoms above (what skin looks like, parts of body, how long have you had it for, what makes it better or worse?):

_____

_____

Is your skin dry or oily? _____

MUSCULOSKELETAL HEALTH:

Do you suffer form any of the following conditions?

☐ arthritis ☐ rheumatoid arthritis
☐ osteoarthritis ☐ gout

Describe symptoms of the condition above and when you were diagnosed.
Include joints affected, treatments and were they successful, what makes it better?

Do you have any other musculoskeletal problems? Explain.

EXERCISE AND FITNESS:

How often do you exercise and what type of exercise do you do?

Where do you rate your fitness?

(Not Fit) ☐ 1 ... ☐ 2 ... ☐ 3 ... ☐ 4 ... ☐ 5 ... ☐ 6 ... ☐ 7 ... ☐ 8 ... ☐ 9 ... ☐ 10 (Very Fit)

If you're an athlete, please include your training schedule, details about energy levels during and after training, how well you recover and any other relevant information.

WEIGHT:

Are you happy with your weight? Do you feel you need to lose or gain weight?

What is your weight and height?

Do you have a history of dieting? Explain.

Have you ever suffered from an eating disorder?

For athletes, do you need to lose body fat or put on muscle mass?

PAST HEALTH HISTORY:

As a child, did you suffer from any recurring infections?
(colds and flu, tonsillitis, ear infections, bronchitis):

Please list any other health events, including viruses, injuries, hospitalisations, and operations in the time-line below:

0-5 years:

5-10 years:

10-20 years:

20-30 years:

30-40 years:

40-50 years:

50-60 years:

60+ years:

FAMILY HEALTH HISTORY:

List any known family diseases or illnesses such as diabetes, cancer, heart disease and metal illness (depression, bi-polar, schizophrenia):

ADDITIONAL INFORMATION:

Is there anything else you would like to mention that you think may be affecting your health?

ONLINE NUTRITIONAL CONSULTATION CONSENT FORM

Holistic nutrition views the body as a whole and every body is a specialized, independent organism with biochemical individuality. Each client is dealt with on an individual basis. Holistic nutrition incorporates not only the body, but also the mind and spirit as well.

A holistic nutritionist will help educate you about the best food and lifestyle choices for YOU. They will help you understand the truth about real food and wellness, and help you make the right choices to find your optimum self.

At times, natural medicines are recommended in order to stimulate the body's inherent healing capacity. A number of different approaches are used, such as dietary changes, nutritional supplements, herbs, homeopathic remedies, and lifestyle changes.

Natural remedies are generally considered safe and side effect free. Although rare, negative reactions to these natural medicines can occur, such as an allergic reaction to an herb or an aggravation to pre-existing symptoms. Natural medicines should be used with caution when treating some conditions such as in pregnancy, diabetes, heart and liver disease. It is very important, therefore, that you inform your RNCP immediately of any disease process that you are suffering from, or if you are pregnant, suspect you are pregnant or you are breastfeeding.

I have fully read and understand the above information and with this knowledge, I hereby consent to having an online nutritional consultation.

Signature: _____

Date: _____