HOLISTIC NUTRITION INTAKE FORMS

Client name: ______________________________ **Date:** ____________________

Age: _________ **Sex:** M F **Height:** ________ **Weight:** _________

What are your main health concerns/complaints (list in order of importance)?

____

____

How would you rate your current diet on a scale of 0 to 10 (10 being the healthiest)?

☐ *0* ☐ *1* ☐ *2* ☐ *3* ☐ *4* ☐ *5* ☐ *6* ☐ *7* ☐ *8* ☐ *9* ☐ *10*

Check the dietary restrictions that apply:

☐ ***Vegan*** ☐ ***Vegetarian*** ☐ ***Gluten-free*** ☐ ***Dairy-free***

☐ ***Paleo*** ☐ ***Sugar-free*** ***Other:*** ____

How would your rate your current exercise/physical activity levels (10 = highly active)?

☐ *0* ☐ *1* ☐ *2* ☐ *3* ☐ *4* ☐ *5* ☐ *6* ☐ *7* ☐ *8* ☐ *9* ☐ *10*

How would you rate your stress levels (10=high stress levels)?

☐ *0* ☐ *1* ☐ *2* ☐ *3* ☐ *4* ☐ *5* ☐ *6* ☐ *7* ☐ *8* ☐ *9* ☐ *10*

Are you currently taking any medication? ☐ ***Yes*** ☐ ***No***

List all medications and the reason(s) for each.

____

____

Have you taken antibiotics over the last 5 years? ☐ ***Yes*** ☐ ***No***

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages:

____

____

Do you have any allergies or sensitivities? ☐ ***Yes*** ☐ ***No*** ***If so, please list:***

____

Do you have any anaphylaxis (life-threatening allergy)? If so, please describe:

____

***Women only :** Are you currently pregnant?* ☐ *Yes* ☐ *No* *Breastfeeding?* ☐ *Yes* ☐ *No*

Are you currently on birth control pills? ☐ ***Yes*** ☐ ***No***

Are you experiencing any of the symptoms below? Write a number in the grey boxes.

- 1 for mild or rarely occurring **- 2** for moderate or regularly occurring

- 3 for severe or often occurring (Leave blank if the symptom/statement does not apply)

General fatigue or weakness		Cold hands and feet	
Difficulty losing weight		Varicose veins	
Frequent illness/infections		Feeling out of control	
High stress lifestyle		Food/chemical sensitivities	
Smoking		Frequent yeast/fungus problems	
Caffeine addiction		Bones break easily, osteoporosis	
Bad breath/body odour		Too little exercise	
Constipation		Excessive mucous	
Bags under eyes		Shortness of breath climbing stairs	
Cravings for sugar/bread/alcohol		Tingling in lips, fingers, arms, legs	
Difficulty digesting certain foods		Chest pains	
Antibiotic use in the last 10 years		Very rapid or very slow heart beat	
Allergies		Painful, hard or thin bowel movements	
Poor concentration/memory		Alternating constipation/diarrhea	
Belching/burping after meals		Recurrent bladder infections	
Skin/complexion issues		Female: Menopause, hot flashes	
Frequent consumption of red meat		Female: PMS	
Regular dairy consumption		Difficult urination	
Heavy alcohol consumption		Swollen glands, puffy throat	
Exposure to chemicals/toxins		Lower abdominal pain	
Frequent mood swings		Frequent need to urinate	
Depressed and/or irritable		Joint pain	
Brittle fingernails		Sinus inflammation	
Dry, brittle hair, split ends		Arthritis	
High fat diet		Sudden weight gain/loss	
Nervousness/anxiety/tension		Headaches/migraines	
Insomnia/restless sleep		Female: Taking birth control pills	
Low fibre diet		Lower back pains	
Muscle cramps		Dry, flaky skin	
Sleepy when sitting up		Drink less than 6 cups of water a day	
Female: menstrual cramps		Water retention	
Bronchitis/asthma		Low sex drive	
Cellulite		Feeling heavy/bloated after meals	

Please circle the following symptoms you have experienced: (O = Occasional; F = Frequent)

UNDERACTIVE STOMACH

Symptom		Symptom		Symptom	
Excessive gas	O F	Vertical striations on fingernails	O F	Eating in a hurry	O F
Stomach bloating	O F	Heavy feeling after eating	O F	Acne	O F
Sleepy after eating	O F	Nausea after supplements	O F	Bad breath	O F

OVERACTIVE STOMACH

Symptom		Symptom		Symptom	
Gastric ulcer	O F	Burning sensation in stomach	O F	Gastritis	O F
Blood in stool	O F	Stomach pain after eating	O F	Lower back pain	O F

LIVER

Symptom		Symptom		Symptom	
Excessive body odour	O F	Yellow fingernails	O F	Migraines	O F
Oily food causes nausea	O F	Oily skin on nose and forehead	O F	Food allergies	O F
Weight gain around abdomen	O F	Discomfort underneath right ribcage	O F	Irritable/easily angered	O F
Constipation	O F	Difficulty losing weight	O F	Acne	O F
High cholesterol	O F	Onions/cabbage/ radishes cause bloating	O F	Bad breath	O F

GALLBLADDER

Symptom		Symptom		Symptom	
Gallstones	O F	High blood cholesterol	O F	Constipation	O F
Pain in right upper abdomen	O F	Clay coloured stool	O F	Foul odoured stool	O F

DYSGLYCEMIA

Symptom		Symptom		Symptom	
Lose temper easily	O F	Hungry soon after eating	O F	Fatigue	O F
Overweight	O F	Strong cravings for sweets/carbs	O F	Feeling faint	O F
Family history of diabetes	O F	Nervous feelings relieved by eating	O F	Irritable if you skip a meal	O F
Addicted to coffee	O F	Frequent midnight snacks	O F	Depression	O F

CANDIDIASIS

Symptom		Symptom		Symptom	
Extreme fatigue	O F	Crave sugars/bread/alcohol	O F	Unclear thinking	O F
Recurrent vaginal infections	O F	Abnormal muscle aches from exercise	O F	Depression/anger for no reason	O F
White coated tongue	O F	Skin flushes/rashes/ acne/psoriasis	O F	Panic attacks	O F

Please circle the following symptoms you have experienced: (O = Occasional; F = Frequent)

ALLERGIES

Acne/eczema	O	F	Frequent headaches	O	F	Poor concentration	O	F
Rapid pulse	O	F	Dark circles under eyes	O	F	Nosebleeds	O	F
Hay fever	O	F	IBS/IBD/Crohn's disease	O	F	Bloating after certain foods	O	F

OVERACTIVE THYROID

Insomnia	O	F	Trembling hands	O	F	Heart racing	O	F
Excessive sweating	O	F	Increased appetite	O	F	Nervousness	O	F

UNDERACTIVE THYROID

Low energy in the morning	O	F	Feel stiff after sitting for some time	O	F	Diminished sex drive	O	F
Sluggishness	O	F	Cold hands and feet	O	F	Mood swings	O	F
Gain weight easily	O	F	Low body temperature	O	F	Constipation	O	F
Flaky, dry skin	O	F	Difficulty losing weight	O	F	Mercury fillings	O	F
High cholesterol	O	F	Low pulse rate	O	F	Wide/square nails	O	F

PITUITARY

Infertility	O	F	Lose of menstrual function	O	F	Excessive urination	O	F
Moody	O	F	Cold hands/feet	O	F	Pain in left side of upper neck	O	F

ADRENALS

Excessive perspiration	O	F	Stress or emotional upset causes exhaustion	O	F	Neck/shoulder tension	O	F
Rapid pulse	O	F	Occasional cold sweats	O	F	Short temper	O	F
High or low blood pressure	O	F	Tightness in throat when emotionally disturbed	O	F	Frequent headaches	O	F

SKELETAL - MUSCULAR

Joint pain	O	F	Muscle pain	O	F	Sprains	O	F
Stiffness in spine	O	F	Tingling in extremities	O	F	Muscle weakness	O	F
Lack of exercise	O	F	Rounding of shoulders/stooping	O	F	Muscle spasms	O	F

CLIENT AGREEMENT FORM

Your signature below acknowledges the following:

A Registered Holistic Nutritionist (RHN) uses a variety of combinations of food and nutrients to help individuals achieve optimal mental/emotional, physical, and spiritual health. It can be used as a preventive health approach for the average person without any ailments or as a way to stimulate the body to balance itself from diagnosed illnesses and disorders. The focus is on eating foods that provide your body with the highest levels of nutritional value and supplementing the diet with vitamins, minerals, etc. when necessary. Forms of support include, but are not limited to: individualized wellness programs, entailing a comprehensive menu plan and setting realistic goals; education and support around label reading; lifestyle modifications; and grocery store tours.

I hereby acknowledge that I am willing to provide my RHN with the information necessary for them to fully understand my medical history, presenting symptoms, and health goals I wish to achieve in our work together. I thereby consent to a thorough case history. This record will be kept confidential and will not be released to others unless so directed by myself or unless required by law.

I understand that holistic nutrition can be employed in conjunction with other forms of therapy and need not be considered exclusively beneficial. I acknowledge that working with other health care professionals will provide a more comprehensive and balanced wellness program.

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 or medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. Holistic nutrition does not substitute or replace routine medical visits, tests, or other medicines prescribed by other health care practitioners.

I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with holistic nutrition include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, and interactions with prescription medications.

As with all forms of therapy, I understand that holistic nutrition also has its limitations and thus I understand that the results are not guaranteed. Nor do I expect the RHN be able to anticipate and explain all risks and complications prior to implementing a personal health plan.

With this knowledge, I voluntarily consent to work with an RHN and I intend for this consent form to cover my entire course of treatment with the RHN, including the personal health plan in its entirety. I understand that I am free to withdraw my consent at any time.

1. I understand that working with a holistic nutritionist is a joint responsibility between me, (the client) and the practitioner. Improving my lifestyle can be as important as the remedies and recommendations.

2. I recognize that holistic nutrition is not an isolated system and that Registered Holistic Nutritionists welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.

CLIENT NAME:____________________________________

CLIENT SIGNATURE:________________________________ DATE: ________________________________

SOURCE CENTRE
FOR HEALTH & WELLNESS

SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms.
http://www.sourcecentre.ca/about/more/terms-service/

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at http://www.sourcecentre.ca/about/more/privacy/

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

Sharing of Personal Health Information with other Source Centre Practitioners

I consent to Source Centre practitioners, whose care I am under, sharing personal health information amongst themselves with regards to my care, for the purpose of enhanced clinical outcomes Y ❍ N ❍

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have about the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

Signature ____

Client Name ______________________________________ Date_______________________

Signature of parent or Guardian (for anyone under the age of 18):

Signature ____

Guardian/Parent Name _______________________________ Date_______________________