ANDREA HILL

HOLISTIC NUTRITION

Eat Real. Live Well. Be Inspired.

Intake *form*

Thank you for taking the time to complete your health and wellness questionnaire.

NOTE: All the information gathered is completely confidential and will not be shared with any third parties.
Please be as candid and open as possible to get the most out of your session.

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CLIENT INFORMATION

Full Name: _____

Date of Birth: _____ /_____ /_____
mm dd yyyy

Primary phone: _____

Email address: _____

Marital status: _____

Children? If yes, how many? _____

Please enter your address:

No. & Street: _____

Apt #, Unit #, Address Line 2: _____

P.O. Box: _____

Postal code: _____

MAIN HEALTH CONCERNS

Please list your main health concerns: (Digestion, skin health, migraines/headaches, weight loss/gain, sports nutrition etc.)

YOUR HEALTH HISTORY

List any and all diagnosis you have received for any health concern recently or in the past:

Are you working with any other health care practitioners? **Please check all that apply.**

_____Medical Doctor _____ Naturopath _____ Acupuncturist _____ Herbalist _____ Psychiatrist

_____ Chiropractor _____ Osteopath _____ Homeopath _____ Massage Therapist

Indicate how many times you've been on antibiotics over the past ten (10) years: _____

List all your current medications:

MEDICATION	DURATION	REASON/CONDITION

List all your current supplements (vitamins, minerals, herbs):

NATURAL HEALTH PRODUCT	DOSE	DURATION	REASON/CONDITION

List all health issues (diabetes, high blood pressure, cancer, etc.) of parents and siblings:

Please check any symptoms you are currently experiencing:

_____ Headaches	_____ Itchy eyes	_____ Skin rash	_____ Brittle nails	_____ Itchy Skin
_____Dry scalp	_____ Oily skin	_____ Hay fever	_____ Runny nose	_____ Coated tongue
_____ White spots on nails	_____ Ridges on nails	_____ Red bumps on back of arms	_____Dry skin, cold hands or feet	

Hours of sleep per night: _____ 3 - 5 _____ 6 - 7 _____ 8 - 10+

Do you exercise? If yes, indicate what you do and how often:

Do you drink caffeinated beverages? If so, how many per day/week?

_____ Yes _____ No _____ per day _____ per week

Do you drink carbonated beverages? If so, how many per day/week? Any diet drinks?

_____ Yes _____ No _____ per day _____ per week _____ Yes _____ No

Indicate your level of energy (1 being low, 5 being normal, and 10 being high) on an average day:

1	2	3	4	5	6	7	8	9	10
LOW				NORMAL					HIGH

Does your energy change throughout the day? (Write LOW, NORMAL, or HIGH in the corresponding time).

_____	_____	_____	_____	_____	_____
6 - 9 am	9 am - Noon	Noon – 3 pm	3 pm	4 pm – 6 pm	6 pm – bedtime

Do you have any known allergies or suspected food intolerances? List all.

Check all digestive concerns you experience either now or have in the past.

Bloating _____ Constipation _____ Heartburn _____ Gas _____ Loose stools _____

Indigestion _____ Cramping _____ Diarrhea _____

How many bowel movements do you have a day? 0 _____ 1 _____ 2+ _____

Do you have any cravings? If so, list all.

List the top 5 foods you eat the most often:

1.

2.

3.

4.

5.

Do you have any dietary restrictions? (For example, no red meat, vegan, vegetarian, no milk, etc.). **Please be very specific.**

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

Do you consume alcohol?

_____ Yes _____ No

If yes, how much and how often?

_____ per day _____ per week

Do you smoke?

_____ Yes _____ No

If yes, how much and how often?

_____ per day _____ per week

How many glasses of water do you drink a day?

How many fruits do you eat per day? _____ (1 serving = 1 apple)

How many vegetables do you eat per day? _____ (1 serving = 1 cup broccoli)

Are the fruits and vegetables organic? _____ Yes _____ No _____ Sometimes

YOUR EMOTIONAL HEALTH

Has there been any significant emotional trauma in your life? Divorce, separation, family problems, death of someone close, abuse, etc. **Please describe.**

Do you tend to eat MORE or LESS when stressed?

Indicate your stress level (1 being low and 10 being high) on an average day

1	2	3	4	5	6	7	8	9	10
LOW									HIGH

List the source of your stress. **Be specific.**

What is your method of coping with stress?

Do you have or have you had an eating disorder (either under-eating or overeating)? Please explain.

YOUR REPRODUCTIVE HEALTH – WOMEN ONLY

Please check any symptoms of PMS you experience?

_____ Cramping _____ Bloating _____ Headaches _____ Change in mood

_____ Irritability _____ Breast tenderness

Please check any symptoms of menopause you experience?

_____ Hot flashes _____ Cravings _____ Headaches _____ Change in mood

_____ Irritability _____ Weight gain

Do you experience emotional upset at the same time each month? **If so, be specific – depression, anxiety, nervousness, excitability, extreme emotions.**

How often do you have a menstrual cycle? _____ a year

Are you on birth control? _____ Yes _____ No If yes, how many months/years? _____ Months _____ Years

Are you on any form of hormone replacement? Synthetic or Natural? _____ Yes _____ No

If yes, how many months/years? _____ Months _____ Years

Have you had a miscarriage? _____ Yes _____ No If yes, how many? _____

Have you had fertility treatments? _____ Yes _____ No

If yes, please describe.

YOUR NUTRITIONAL EXPECTATIONS

What are you expecting from your nutrition program?

Have you tried any other nutrition programs or diets in the past to reach your goals and were you successful?

How would you rate your nutrition in these areas: poor, needs improvement, good, excellent

Scheduling/planning: _____

Balancing carbs, protein, fat ratios: _____

Level of commitment to a program: _____

Please include anything else you want to cover during your nutrition session.

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THANK YOU FOR TAKING THE TIME TO COMPLETE YOUR HEALTH & WELLNESS QUESTIONNAIRE.

I look forward to supporting you on your journey to health & wellness!

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Service Terms *& Conditions*

NO-SHOWS, SCHEDULING & CANCELLATIONS

Not showing up for appointments, or rescheduling/cancelling with less than 12 hours' notice will be billed in full (or deducted from your program package). All fees are non-refundable and non-transferable.

NOTE: For best results, it is recommended that sessions be used within a three- (3) month period. Sessions will expire after six- (6) months from the time of purchase.

PAYMENT POLICY

Payments are due on – or prior to – the day of service. Payments can be made in cash, debit, credit card, online (Butterfield Bank: "Nourishing Life Ltd."), or check payable to Nourishing Life, Ltd.

_____ *By submitting this form to Andrea Hill Holistic Nutrition, I acknowledge and understand the terms and conditions outlined above.*

Date: _____/_____/_____
mm dd yyyy