BETTER LIVING Nutrition

...Caring for the whole you

# *Vitamin Consultation*

*Thank you for taking the time to invest in your health and wellbeing.*

Holistic nutrition is a rapidly growing area of healthcare that is based on the principles of balancing and harmonizing the whole body. This is done through diet and lifestyle changes specific to you.

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 the get the most out of your session.

## CLIENT INFORMATION

Full Name _____ Date of birth _____ _____ _____ Age_____
mm dd yyyy

Primary phone _____ Email address _____

Cell phone _____ Work Phone _____

Emergency Contact _____ Phone (for emergency) _____

Marital status _____ Children? If yes, how many? _____

Occupation _____ Hours of work per day _____

Please enter your address:

No. & Street _____ Apt #, Unit #, PO Box # _____

City, Town _____ Province, State _____

Postal code _____ Country _____

## MAIN HEALTH CONCERNS

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

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## YOUR HEALTH HISTORY

List any and all diagnosis you have received for any health concern recently or in the past, as far back as childhood:

What therapies are you Currently using?

**Please check all that apply.**

- ☐ Medical Doctor
- ☐ Acupuncturie
- ☐ Massage
- ☐ Homeopathy
- ☐ Diet
- ☐ Dentist
- ☐ Psychiatry
- ☐ Osteopath
- ☐ Chinese Medicine
- ☐ Prescription Medicine
- ☐ Naturopath
- ☐ Chiropractor
- ☐ Herbs
- ☐ Exercise
- ☐ Other_____

List all of your current medications.

| MEDICATIONS | DURATION | REASON / CONDITION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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

| NATURAL HEALTH PRODUCT | DOSE | DURATION | REASON / CONDITION |
|---|---|---|---|
| | | | |
| | | | |
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Check all digestive concerns you experience either now or have in the past.

☐ Bloating ☐ Gas ☐ Cramping

☐ Constipation ☐ Loose Stools ☐ Diarrhea

☐ Heartburn ☐ Indigestion ☐ Burping

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

How many times a day do you eat? Main meals_____ Snacks_____

What time of day is your last Meal?_____ Snack?_____

Do you skip meals? ☐ Yes ☐ No

If you skip a meal do you often feel... ☐ irritable ☐ weak ☐ Lightheaded

How long does it usually take you to eat?_____

Do you usually consume a beverage with your ☐ Yes ☐ No

Please list any food aversions and/or foods you dislike:

_____

_____

_____

Do you have any cravings? Please check all.

☐ sweets/desserts ☐ chocolate ☐ sodas

☐ fried foods ☐ peanuts ☐ bread/pasta

☐ alcoholic drinks ☐ meat ☐ fish

☐ cheese Other_____

List the top 5 foods you eat the most often.

1 _____ 4 _____

2 _____ 5 _____

3 On a typical day what would you eat for:

Breakfast:_____

Lunch: _____

Dinner: _____

**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 purpose 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. All information will be kept strictly confidential.

_____ Date:_____

Signature