Holistic Nutrition for the Whole You

Confidential Consultation Questionnaire

Date:_____

Have you been referred to us? Please give us their name so we can thank them. _____

Name: _____ DOB: _____ Age:_____ Sex: M F

☐Married? ☐Divorced? ☐Single

Mailing Address:_____

Shipping Address:_____

City:_____ State / Province:_____ Zip/ Postal Code: _____

Day time Phone (_____)_____ Cell Phone (_____)_____

Evening Phone (_____)_____ Email:_____ @_____

Do you use Social Media? i.e. Facebook Twitter Instagram Pintrist Linkdn Veteran or Active Military? Y N

What is or was you occupation_____

Do you have a degree and or a journeyman? Y N _____

Primary Health Care Provider: _____ Insurance*:_____
**we do not provide Insurance billing codes*

Average Blood Sugar:_____

Blood Pressure: _____/_____ Pulse: _____

Weight:_____ Height:_____ Blood Type :_____

Hours of Sleep Nightly_____

Cultural Heritage: (e*.g. English, French, Scandinavian, Italian, Irish, German, Native American, African America*)_____

Your Cholesterol #'s HDL:_____ LDL:_____

VLDL:_____ Triglycerides: _____

(For Women) Are you pregnant? Y N Are you still menstruating? Y N When was your last period? _____

Are your periods: Heavy Regular Light Spotty Painful Irregular Have You Had a DNC? Y N

Have you had a Hysterectomy? Y N Ovaries removed? Y N HRT Therapies Y N BHRT Y N

Do you have vaginal dryness? Y N Are you on Birth Control? Pill Shot Implant Patch Other:_____

Have you had any miscarriages? Y N

(Men & Women) Describe your interest in sex. good fair poor excellent Are you sexually active? Y N

Do you have living children? Y N

Family History – please circle all that pertain:

Alcoholism	Gout	Osteoporosis
Alzheimer's	High Blood Pressure	Stroke
Arthritic Osteo or RA	High Cholesterol	Thyroid Disorder
Cancer _____	Lupus	Type 1 Diabetes
Depression	Menstrual / Fertility Problems	Type 2 Diabetes
Digestive Disorders	Obesity	Varicose veins

Have you had any of the following tests? Please circle all that pertain.

Salivary Hormone	Homocysteine	Food Allergy
Thyroid fT4 – fT3 – TSH – TPO	High Sensitivity CRP	(which foods are you most reactive to?
Vitamin D3	Ferritin	_____
PSA	Iodine (urine)	_____
A1C hem	DNA/Gene	_____

(For Men) Your last prostate exam?_____ Have you had prostate surgery? Y N

Have you had any surgery? Y N If yes, please tell us what for and when:

_____

_____

Are you currently under a physician's care? Y N What for? _____

Are you currently on any medications prescribed by a health care provider? Y N Please list them below

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any nutritional supplements? Y N If yes, please list the name brands, product, and dosage.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you a vegetarian? Y N Do you have religious dietary needs? Y N

How many times in the last two years have you been on antibiotics ? _____When?_____

How frequent are your bowel movements? One a day Twice Daily More? _____ Once a week

Describe your stool consistency?

Bloody	Hard & Dry	Soft & Easy
Chronic Constipation	Hard & Sinks	Strong/Fowl Smelling
Dark in Color	Ileostomy Bag	White or Oily Looking
Diarrhea	Light in color	
Easy Floater	Loose Sometimes Watery	

How frequently do you urinate? _____ Color of Urine: Dark Yellow Brown Orange Yellow Light Yellow Clear

Does your urine have a strong odor? Y N Do You Have Kidney Stones? Y N Unknown

Please list the foods you eat the most frequently.

_____

_____

Are there any foods you crave? _____ Foods you can not eat for any reason?_____

Are you allergic to: Egg's Shellfish Mushrooms Nut's Other: _____

Describe a typical breakfast, lunch and dinner:

Breakfast:_____ Lunch:_____ Dinner_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you ever skip meals? Y N Do you eat between meal snacks? Y N

List Snacks_____

Do you use: Margarine Butter Olive Oil Corn Oil Coconut Oil Canola Oil

Other: _____

Do you like spicy foods or condiments? Y N Do you use real mayonnaise? Y N

Do you use salad dressing from the refrigerator section at the market or off the shelf: Shelf Refrigerated

Do you eat nuts? Y N Raw Roasted What is your favorite nut? _____

Do you eat? Please circle all that apply:

White Bread	Whole Grain Pasta	Russet Potatoes
Whole Grain Bread	Rice Pasta	Red Potatoes
Sprouted Grain Bread	White Rice	Turnips
Whole Wheat Bread	Basmati Rice	Tropical Fruits (i.e. pineapple, mango, bananas)
Gluten Free Bread	Brown Rice	Quinoa
Pasta	Beets	Gluten Free Foods

How many times a week do you eat out or eat prepared packaged or canned food? _____

Do you eat fish? Y N What types: _____

What is your primary meat or vegetable protein source? _____

Do you eat vegetables? fresh frozen canned How many times a week? _____

Do you eat fruit? fresh frozen canned dried How many times a week? _____

Do you Drink?

Alcohol	Green Tea Decaf	Energy Drink
Coffee Decaf	Red Tea	Soda Pop Diet
How many cups of coffee a day?_____	Herbal Tea	How many pops a day? _____
Black Tea Decaf	Filtered Water	Water in ounces Daily _____

Do you prefer food over supplements? Y N

Do you have a hard time remembering to take supplements? Y N

Are pills hard to swallow? Y N

Do you support to help motivate you with your health choices? Y N

Do you get regular exercise? 1-7 days a week: _____ How many hours or minutes do you exercise? _____

Do you spend time out in the sun? Y N Do you use Sunscreen? Y N SPF?_____ Do you use full spectrum lighting? Y N

Do you attend a Church, Synagogue, Mosque, Temple, Drumming, or Centering Group on a regular basis? Y N

How often do you listen to music? _____ What is your favorite color? _____

What do you do to pamper or treat yourself? (eg. hunting, camping, fishing, skiing, spa, massage, new cloths, shopping, reading, manicure, sunbathing)

_____

Please tell us what your goal is by requesting a consultation.

_____

_____

_____

_____

_____

PLEASE CHECK OR CIRCLE ALL BOXES AND OR ANSWERS THAT APPLY TO YOU:

Many of these require a diagnosis from a licensed healthcare provider; others are personal evaluations from you.

- ☐ Abdominal Fat
- ☐ ADD / ADHD / Autism
- ☐ Adrenal Fatigue / Addison's Disease
- ☐ Allergies / Seasonal, Food, Environment
- ☐ Alzheimer's / Parkinson's Disease
- ☐ Anemia
- ☐ Appendix Removed
- ☐ Asthma
- ☐ Back / Neck Pain / Sciatica / Herniated / Bulged / Slipped / Degeneration / Ruptured disk
- ☐ Bitten by a Tick
- ☐ Blood Clots /Stroke / Hypertension
- ☐ Blood Transfusions
- ☐ Bone Spurs
- ☐ Cancer / Cancer Treatments
- ☐ Candida
- ☐ Cardiovascular Disease
- ☐ Carpal Tunnel Syndrome
- ☐ Cataracts / Floaters / Macular Degeneration
- ☐ Cholesterol (High) / High Triglycerides
- ☐ Chronic Fatigue Syndrome
- ☐ Celiac Disease
- ☐ Cold Body Temp.
- ☐ Congestive Heart Failuar
- ☐ Constipation
- ☐ COPD
- ☐ Cravings
- ☐ Cushing's syndrome
- ☐ Cystic Fibrosis
- ☐ Dental Problems
- ☐ Dentures / Implants
- ☐ Diabetes 1 or 2
- ☐ Digestive Problems : *IBS / Crohn's / Gastric Bypass / Celiac disease / Colitis / Ulcers*
- ☐ Decreased Muscle Mass
- ☐ Decreased Urine Flow
- ☐ Eating Disorder
- ☐ Endometriosis
- ☐ Enlarged Prostate
- ☐ Environmental Poisoning
- ☐ Epilepsy
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Fibrocystic Breasts
- ☐ Fibromyalgia
- ☐ Fingernails: Chip easily, dry, brittle, peel, weak, slow growing
- ☐ Flatulence / GAS
- ☐ Fluid Retention
- ☐ Food Allergies / Food Sensitivity
- ☐ Frequent Urination
- ☐ Gallbladder Removal
- ☐ Hair – Dry / Brittle / Losing / Dandruff / "Straw like" or Unmanageable hair
- ☐ Hard Bumps on Arms, Thighs or Elbows
- ☐ Hashimoto's Thyroiditis
- ☐ Headaches / Cluster, Migraine, Sinus
- ☐ Hearing Loss / Ringing / Infections / Wax
- ☐ Heartburn / Acid reflux
- ☐ Hemorrhoids
- ☐ Hepatitis A B C
- ☐ Herpes 1 -2
- ☐ High-Risk Sexual Activity
- ☐ Histamine Intolerance
- ☐ HIV/AIDS
- ☐ Hypoglycemia
- ☐ Incontinence
- ☐ Insomnia
- ☐ Irregular Heart Rhythm
- ☐ Irritability / Depression / SAD
- ☐ IV Drug use
- ☐ Kidney Disease
- ☐ Leg Twitches or Cramps
- ☐ Losing Weight / or Gaining
- ☐ Low Libido
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Menopause /Hot Flashes
- ☐ Menstrual Cramps / PMS
- ☐ Mood Swings
- ☐ Multiple Sclerosis
- ☐ Muscle Stiffness / Soreness
- ☐ Myocardiopathy
- ☐ OPD
- ☐ Osteomyelitis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Periodontal Disease
- ☐ Polycystic Ovarian Disorder (POD)
- ☐ Prostate Problems / PID
- ☐ Rare Blood Diseases
- ☐ Rheumatoid / Osteoarthritis
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Skin Problems / *Eczema, Rosacea, Acne, Liver spot/ Dry or Oily*
- ☐ Smoking Dependency
- ☐ Snoring /Sleep Apnea
- ☐ Spleen Removed
- ☐ Sports injuries
- ☐ STDs
- ☐ Stress / Anxiety / PTSD
- ☐ Syndrome X or Metabolic Syndrome
- ☐ Tattoos
- ☐ Thinning Skin
- ☐ Thyroid Problems / Hypo / Hyper
- ☐ Tonsillectomy / Adenoids
- ☐ Urinary Tract Problems / Cystitis
- ☐ Use Recreational Drugs / Medical Marijuana
- ☐ Varicose Veins / Spider Veins
- ☐ Von Willebrand
- ☐ Weakened Immune System: *Frequent Colds or Flu*
- ☐ Wilson's Syndrome

How our consultation services work

Initial Consultation:
A free 15 min introductory session, either by interactive audio and video technology, via email or phone. Learn more about Holistic Nutrition for the Whole You, and if we are the right fit for you.

Programs made for you:
For First Time Clients, are encouraged to select the **Taking Back Control of Your Health** package to kick start your journey. Customized programs to fit your needs also available.

What is Teleconsulting/Telemedicine?
Teleconsulting/Telemedicine is the delivery of health care services using interactive audio and video technology, where the client/patient and provider are not in the same physical location. During your telemedicine consultation with a provider, details of your medical or health history and personal health information may be discussed through the use of interactive audio, video, and other telecommunications technology.

Depending on your medical or health history and specific complaint, you may be asked to provide information through other electronic means and verify your identity with a driver's license or another legal document.

The telemedicine services you receive are not intended to replace a primary care physician relationship or for prescribing, diagnosing or treatment. You should seek emergency help or follow-up care when recommended or when otherwise needed, and continue to consult with your primary care physician and other health care professionals as recommended.

Your Contract with Holistic Nutrition for the Whole You & Fraud Prevention and Security statement.

- To access nutrition consulting services, you represent and warrant that you are of legal age to sign a binding contract and possess the legal right and ability, on behalf of yourself or a minor child of whom you are a parent or legal guardian, to agree to these Terms of Use.
- You agree to fully, completely, accurately and truthfully provide, including, but not limited to, your name, mailing address, phone number, email and password, which become your ID and credentials.
- You agree to prohibit anyone else from using your password and credentials, and you agree to immediately notify Holistic Nutrition for the Whole You of any actual or suspected unauthorized use of your ID or credentials or other security concerns of which you become aware.
- At no point will this office or our affiliates retain, store or file credit card information. This information must be presented at the date of service with ID.
- Client health information may be used for anonymous research. At no time will personal names, addresses or potentially other sensitive information be used.
- Holistic Nutrition for the Whole You may contact you by telephone, mail or email to verify your information. Holistic Nutrition for the Whole You may request details from you, and you agree to provide such details to ensure you have not fraudulently contracted services. If you do not provide this information in the manner requested within 14 days of the request, Holistic Nutrition for the Whole You reserves the right to suspend, discontinue or deny services, until the information is provided by the customer as requested.
- This information is for nutritional evaluation based on family history or medically diagnosed health challenges; it is not to be construed or used as a medical diagnosis, treatment or prescriptive. The information presented is intended for educational purposes only and is not designed to be a substitute for professional medical advice, diagnosis, or treatment. We are not liable for any personal injury or mental anguish including death, caused by the use of any information provided by third parties or products you purchase. The information provided is intended as educational, and we do not have any control over how you may choose to use said information. Therefore we cannot be held responsible for your actions.
- We do not control the manufacture of dietary supplements, topical products, formulation, or quality of these products, nor do we control any statements written by third parties about the products or products listed. Any information or products you may choose to use requires your responsibility in accordance with the manufacturer's guidelines or those of your health care provider.
- All testing is done through third party labs; this office provides you with information about these labs, it is up to you to pursue and purchase the use of their services. Insurance billing requires coding from a recognized medical provider. Holistic Nutrition for the Whole You will not provide you with any said coding for insurance reimbursement.

I understand and agree to the conditions listed here and am requesting a nutritional consultation:

_____ Date:_____