Melanie Grime RHN

INTAKE FORM

Name:____ Date:____

Address:____ Home Phone: (___)__________________________________

City:___________________Postal Code:_________________ Business Phone:(___)_______________________________

Company:____ Date of Birth/Age:_________________________________

Referred By:_______________________________________ E-mail:____

Occupation: _______________________________________

Health Concerns

1. What is your main purpose in coming here today?

____

2. What are your main health concerns/complaints?

____

3. When did you first experience these concerns?

____

4. How have you dealt with these concerns in the past?

❑ doctors

❑ self-care

5. Have you experienced any success with these approaches? ❑ Yes ❑ No

6. What other health practitioners are you currently seeing? List name, speciality and phone # below:

____

7. Please list the date and description of any surgical procedures you have had:

____

8. How often did you take antibiotics in infancy/childhood? (rarely) 1 2 3 4 5 (frequently)

9. How often did you take antibiotics as a teen? (rarely) 1 2 3 4 5 (frequently)

10. How often have you taken antibiotics as an adult? (rarely) 1 2 3 4 5 (frequently)

11. List all prescription medications you are currently taking

____

12. List all supplements you are currently taking

____

Melanie Grime RHN
Collective Health Clinic 519-941-3100
melaniegrimerhn@gmail.com
www.facebook.com/AdamsAppleNutrition
www.adamsapplenutrition.com

collective HEALTHCLINIC

Melanie Grime RHN

Nutritional Status

13. Have you ever seen a Nutritionist before? ❑ Yes ❑ No

14. List 3 things you liked about your previous experience with a Nutritionist 1. ___________ 2.___________ 3. _____________

15. Are there any foods that you avoid because of the way they make you feel: If yes, please name the food and the symptom:

____

16. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives: If so, please explain:

____

17. Are you aware of any delayed symptoms after eating like bloating, gas, sneezing or hives: If so, please explain:

____

18. Are there any foods you crave?: If so, please explain:

____

19. Describe your diet at the onset of your health concerns:

____

20. Do you have any known allergies or sensitivities? If so, please list:

____

21. Which of the following foods do you consume regularly?

❑ Soda ❑ Diet Soda ❑ Refined Sugar ❑ Alcohol ❑ Fast Food ❑ Gluten (Wheat, Rye, Barley) ❑ Dairy (Milk, Cheese, Yogurt) ❑ Coffee

22. Are you currently on a special diet?

❑ Ovo-Lacto ❑ Diabetic ❑ Dairy-Free ❑ Vegetarian ❑ Vegan ❑ Paleo ❑ Blood Type ❑ Raw ❑ Refined Sugar-Free

❑ Gluten-Free ❑ Other

23. What % of your meals are home-cooked?

❑ 10-20 ❑ 30-40 ❑ 50 ❑ 60-70 ❑ 80-90 ❑ 100

24. How often do you dine out? ❑ Seldom ❑ 1 per week ❑ 2-3 per week ❑ More than 3

25. How frequent do you eat fast foods? ❑ Seldom ❑ 1 per week ❑ 2-4 per week ❑ More than 4

26. Is there anything else I should know about your current diet, history or relationship to food? If yes, please explain:

____

Melanie Grime RHN
Collective Health Clinic 519-941-3100
melaniegrimerhn@gmail.com
www.facebook.com/AdamsAppleNutrition
www.adamsapplenutrition.com

collective HEALTHCLINIC Melanie Grime RHN

Intestinal Status

27. Bowl Movement Frequency: ❑ 1-3 times per day ❑ more than 3 times per day ❑ not regularly every day

28. Bowel Movement Consistency: ❑ soft & well formed ❑ often float ❑ difficult to pass ❑ diarrhea ❑ thin, long or narrow ❑ small and hard ❑ loose but not watery ❑ alternating between hard and loose

29. Bowel Movement Colour: ❑ medium brown ❑ very dark or black ❑ greenish❑ blood is visible❑ variable ❑ yellow, light brown ❑ chalky coloured ❑ greasy, shiny

30. Do you experience intestinal gas: If so, please explain if it is excessive, occasional, odorous etc.

____

31. Do you experience any of the following digestive system symptoms:

❑ Heart Burn ❑ Acid Reflux ❑ Burping ❑ Bloating ❑Bloating

Health History

32. Do you experience any of the following symptoms:

❑ Headaches ❑ Migraines ❑ Hot Flashes ❑ Aches and Pains ❑ Psoriasis ❑Eczema

❑ Dry Skin ❑Cracking Nails ❑ Brittle Hair ❑ Cracking Skin ❑ Congestion

33. Have you ever been diagnosed with any of the following conditions? If yes, briefly describe your symptoms, chosen treatment(s) and dates

❑ Diabetes ❑ High Cholesterol ❑ High Blood Pressure ❑ Depression ❑ Osteoporosis ❑ Heart Disease ❑ Hepatitis ❑ Kidney Disease ❑ Thyroid Disease ❑ Cancer Type:________________________ ❑ Depression ❑ Asthma ❑ Allergies ❑ Anemia ❑ Chronic Yeast Infections ❑ Other

Details: ____

34. My Family History:

❑ Alcoholism ❑ Allergies ❑ Arthritis ❑ Asthma ❑ Cancer ❑ Diabetes ❑ Gall Bladder Problems

❑ Heart Disease ❑ Hypertension ❑ Intestinal Disease ❑ Kidney Disfunction ❑ Osteoporosis ❑ Ulcers

35. Have you been exposed to any chemical or toxic metals (lead, mercury, arsenic, aluminum) ? ❑ Yes ❑ No

36. Do You Smoke ❑ Yes ❑ No

Health Hazards

37. Do odors affect you? ❑ Yes ❑ No

38. Are you or have you been exposed to second-hand smoke? ❑ Yes ❑ No

39. Do you have mercury amalgam fillings? ❑ Yes ❑ No

collective HEALTHCLINIC

Melanie Grime RHN

Lifestyle History

40. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time (i.e. Weight Watchers, Dr Bernstein, Paleo, Isagenix, Juice Fasting, U Weight Loss)

____

41. Have you used or abused ❑alcohol, ❑drugs, ❑meds, ❑ tobacco or ❑ caffeine? If Do you still?

42. How stressed out are you on a regular basis? please circle (best) 1 2 3 4 5 (worst)

43. How do you handle stress? (Exercise, meditate, deep breathing etc)

____

44. How many hours on average do you sleep daily? ____________________

45. Do you sleep through the night on a regular basis? ❑ Yes ❑ No If no, why? ____

46. Can you get to sleep easily? ❑ Yes ❑ No

47. Can you stay asleep? ❑ Yes ❑ No

48. What time do you go to sleep? ______________________ Awaken? _________________________________

49. Do you wake up feeling rested? ❑ Yes ❑ No

50. Have you or your family recently experienced any major life changes? If so, please comment:

____

51. How much time have you had to take off work or school in the last year? ❑0-2 days ❑3-14 days ❑more than 15 days

Women Only

52. Are you or could you be pregnant? ❑ Yes ❑ No

53. How are or were your periods?
____

54. Do or did you have PMS?
____

55. Were your periods painful ? ____

56. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

❑ Yes ❑ No

57. Are you pre-menopausal or menopausal? ❑ Yes ❑ No

58. Are you experiencing any menopausal symptoms? ❑ Yes ❑ No

If yes, please specify ____

59. Have you had a bone density test? ❑ Yes ❑ No If yes, what was the result? ____

60. Have you experienced any ❑yeast infections or ❑urinary tract infections? Are they regular? ❑ Yes ❑ No

61. Have you or do you still take birth control pills? If so, please list length of time and type:______________________________

Melanie Grime RHN
Collective Health Clinic 519-941-3100
melaniegrimerhn@gmail.com
www.facebook.com/AdamsAppleNutrition
www.adamsapplenutrition.com

Melanie Grime RHN

62. Have you had any problems with conception or pregnancy? ❑ Yes ❑ No

63. Are you taking any hormone replacement therapy or hormonal supportive herbs: If so, please list again here

____

Mental Health Status

64. How are your moods in general? Do you experience more than you would like of ❑anxiety? ❑ Depression? ❑ Anger?

65. Describe your usual level of energy (worst) 1 2 3 4 5 6 7 8 9 10 (best)

66. At what point in your life did you feel best ? Why ?

____

Other

67. When was the last time you participated in a regular exercise program? ______________________________________

68. Who is included in your support system? ❑ Spouse ❑ Child ❑ Parent ❑ Sibling ❑ No One

69. Please describe any other information you think would be useful in helping to address your health concern(s)

____

70. What are your health goals and aspirations?

____

Though it may seem odd, please consider why you might want to achieve that for yourself.

CLIENT STATEMENT

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 diagnoses, 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 (printed): ____

Address: ____

City: ____________________________ Province: ___________________ Postal Code: ___________________

Phone (Home): _________________________ Phone (Cell): __________________________

Melanie Grime RHN
Collective Health Clinic 519-941-3100
melaniegrimerhn@gmail.com
www.facebook.com/AdamsAppleNutrition
www.adamsapplenutrition.com

Melanie Grime RHN

Privacy Policy, and 24 Hour Cancellation Policy

I understand that a record will be kept of the nutritional services provided to me. This record will be kept confidential in accordance with the provincial laws and will not be released to others unless so directed by myself unless law requires it.

If required, I understand that Melanie Grime RHN may discuss my case with other healthcare providers.

I understand that I may look at my client file at any time and can request a copy of the file by paying the appropriate fee.

I understand that Melanie Grime RHN and The Better Health Clinic will take all necessary steps to provide adequate privacy of my client file.

24 Hour Cancellation Policy

Melanie Grime RHN takes pride in the quality of care she offers her clients. In order to do this she has a strict cancellation policy. Melanie Grime RHN requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, a fee of $25.00 will be required.

Non-Sufficient Funds (NSF) Cheques

Please note that there will be a $20.00 charge on each NSF cheque.

Client Consent

I have reviewed the above information that explains how Melanie Grime RHN will use my personal information, and the steps Melanie Grime RHN will take to protect my information. I agree that Melanie Grime RHN can collect, use and disclose personal information about______________________ (print name) as set out above in the information about the Clinic's privacy policy. I have reviewed and understand the 24 hour cancellation policy and will accept the $25.00 fee for the appointment if appropriate time is not provided.

Signature:____ Date:_______________________

Melanie Grime RHN
Collective Health Clinic 519-941-3100
melaniegrimerhn@gmail.com
www.facebook.com/AdamsAppleNutrition
www.adamsapplenutrition.com

Melanie Grime RHN

Holistic Nutrition Consulting Informed Consent and Disclaimer

For the services of Melanie Grime, RHN

Before you choose to use the services of a holistic nutritionist, please read the following information **FULLY AND CAREFULLY.**

GOAL: Our basic goal is to encourage people to become knowledgeable about the responsible for their own health, and to bring it to a personal optimum level. Nutritional consulting is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A holistic nutritionist is trained to evaluate your nutritional needs and make recommendations for dietary change and nutritional supplements. A Holistic nutritionist is not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis. Since every human being is unique, we cannot guarantee any specific results from our programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A holistic nutritionist is not a substitute for your family physician or other appropriate healthcare provider. A holistic nutritionist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases.

If you are under the care of another healthcare provider, it is important that you contact your other healthcare providers and alert them to your use of nutritional supplements. Holistic nutritional consulting may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program. If you are using medications of any kind, you are required to alert the holistic nutritionist to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

COMMUNICATIONS: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition. You must stay in contact with Melanie Grime RHN so she can let you know what is happening and the best course of action.

By my/our signature(s) below I/we confirm that I/we have read and fully understand the above disclaimer, are in complete agreement thereto and do freely understand the consent to all terms contained herein.

Name (please Print)____

Signature____ Date_____________________

Melanie Grime RHN
Collective Health Clinic 519-941-3100
melaniegrimerhn@gmail.com
www.facebook.com/AdamsAppleNutrition
www.adamsapplenutrition.com