HOLISTIC WELLNESS
OTTAWA

Natural Nutrition
Intake Form

Name: _____ Date today: _____

Age: _____ Height: _____ Weight: _____ Ideal Weight: _____ Blood Type: _____

This questionnaire will assist in the assessment of your present state of health and the information will assist us in choosing an appropriate direction to take in working toward creating your optimal level of health.
Please answer each of the following questions to the best of your knowledge:

What is your main purpose in coming here today? _____

_____

What are your main health concerns in order of priority? _____

_____

Have you ever been hospitalized? If so why? _____

When?_____

What are your main hobbies and recreation? _____

_____

How many hours a day do you: watch TV? _____ Read? _____ Spend in front of a computer? _____

Do you take vacations regularly? ____ When was your last vacation? _____

Activity level: (circle one)

- Sedentary (no exercise-gardening or house work etc.)
- Moderate (3 to 5 times/week 20-30 mins each session)
- Active (3 to 5 times/week 60 mins each session)
- Very active (3 to 5 times/week 90 mins each session - competitive recreational athlete)
- Extremely active (5 or more times /week 90 mins plus per session - pro athletic level)

List types of exercise: _____

_____

How would you describe your energy levels (please quantify on a scale of 1 to 10)? _____

How many hours of sleep do you get on average? _____ Do you wake feeling rested? _____

How many hours do you work each day? _____ Do you enjoy your work? _____

What level of stress are you experiencing at this time (please quantify on a scale of 1 to 10)? _____

Check your main causes of stress:

health / financial / job-related / interpersonal / marriage / family members / unfulfilled expectations / spiritual

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Do you smoke? Yes ◯ No ◯ (if yes, how many cigarettes per day? ____)

Have you ever smoked? Yes ◯ No ◯ For how long? _____ How long ago did you quit?

Does anyone else smoke in your household? Yes ◯ No ◯ Your workplace? Yes ◯ No ◯

How many cups / bottles / glasses do you drink, on average, per day of the following beverages?

Coffee ____ Tea ____ Water _____ Milk (2%) _____ Milk (skim) _____ Fruit juice _____ Vegetable juice _____

Soft drinks (diet) ____ Soft drinks (reg.) ____ Herbal tea _____ Beer _____ Wine ____ Liquor _____

How often do you have an alcoholic beverage? _____ Have you ever been treated for alcoholism? _____

Circle if you eat, drink or use (even occasionally):

☐ Alcohol	☐ Distilled water	☐ Sugar substitutes (Nutra-Sweet etc.)
☐ Candy	☐ Fried foods	☐ Chewing gum
☐ Luncheon meats	☐ Carbonated beverages	☐ Fast foods
☐ White flour	☐ Margarine	☐ Vitamins/minerals
☐ Chocolate	☐ Potato chips	☐ Refined foods
☐ Spring water	☐ Aluminum pans	☐ Microwave oven

What are you taking now? (vitamins, minerals, herbal remedies, prescription drugs, etc.)

_____

_____

Family history: Hereditary diseases _____

Health of relatives: Siblings: _____

Father: _____ Mother: _____

Dietary habits: list what you ate and drank for your **last three meals**

Breakfast: _____

Lunch: _____

Supper: _____

Snacks _____

Any Additional Details: _____

Are you pregnant? Yes ◯ No ◯
Are you planning or trying to become pregnant? Yes ◯ No ◯

If any of the following symptoms or activities have occurred ***within the past three months*** (unless otherwise specified), please indicate by checking:

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

1	General fatigue or weakness	Select an option	35	Varicose veins	Select an option
2	Difficulty losing weight	Select an option	36	Feeling out of control	Select an option
3	Frequent illness/infections	Select an option	37	Food sensitivities	Select an option
4	High stress lifestyle	Select an option	38	Frequent yeast/fungal issues	Select an option
5	Smoking	Select an option	39	Bones break easily, osteoporosis	Select an option
6	Drinking more than 2 cups coffee/day	Select an option	40	Too little exercise	Select an option
7	Bad breath and/or body odour	Select an option	41	Excessive mucus	Select an option
8	Constipation	Select an option	42	Short of breath climbing stairs	Select an option
9	Bags under eyes	Select an option	43	Tingling in fingers, lips, arms, legs	Select an option
10	Crave sugars, bread, alcohol	Select an option	44	Chest pains	Select an option
11	Difficulty digesting certain foods	Select an option	45	Very rapid or slow heat beat	Select an option
12	Have used antibiotics in past 10 years	Select an option	46	Painful, hard or thin bowel movements	Select an option
13	Allergies	Select an option	47	Alternating constipation/diarrhea	Select an option
14	Poor concentration or memory	Select an option	48	Recurrent bladder infections	Select an option
15	Burping or belching after meals	Select an option	49	Female: Menopause, hot flashes	Select an option
16	Skin/complexion problems	Select an option	50	Female: PMS	Select an option
17	Frequent consumption of red meat	Select an option	51	Difficult urination	Select an option
18	Regular use of dairy products	Select an option	52	Swollen glands, puffy throat	Select an option
19	Heavy alcohol consumption	Select an option	53	Lower abdominal pain	Select an option
20	Exposure to toxins/chemicals	Select an option	54	Frequent need to urinate	Select an option
21	Frequent mood swings	Select an option	55	Joint pain	Select an option
22	Depressed and/or irritable	Select an option	56	Sinus inflammation/discharge	Select an option
23	Brittle fingernails	Select an option	57	Arthritis	Select an option
24	Dry brittle hair, split ends	Select an option	58	Sudden weight gain/loss	Select an option
25	High fat, high cholesterol diet	Select an option	59	Headaches/migraines	Select an option
26	Nervousness/anxiety/tension/worry	Select an option	60	Female: taking birth control pill	Select an option
27	Insomnia/restless sleep	Select an option	61	Lower back pains	Select an option
28	Low fibre diet	Select an option	62	Dry, flaky skin	Select an option
29	Muscle cramps	Select an option	63	Drink less than 6 glasses fluid/day	Select an option
30	Sleepy when sitting up	Select an option	64	Water retention	Select an option
31	Female: menstrual cramps	Select an option	65	Low sex drive	Select an option
32	Bronchitis/asthma/pneumonia/emphysema	Select an option	66	Feeling heavy, bloated after meals	Select an option
33	Cellulite	Select an option	67	Chronic cough	Select an option
34	Cold hands and feet	Select an option			

Consent to nutritional consultation and treatment

I hereby request and consent to nutritional care provided by Emily Stott, RHN.

I understand that the nutrition consultations offer nutritional evaluation, dietary and lifestyle advice and nutritional supplementation.
I understand that methods of nutritional evaluation are not intended to diagnose disease. Rather, these assessments are intended as a guide to developing an appropriate overall program for me to allow my body to return to optimal health.

I understand that is my responsibility to inform Emily Stott of any food allergies, sensitivities and intolerances of which I am aware.

I understand that the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are traditionally considered safe in the practice of nutrition, however, some of these substances may be toxic in large doses.
I understand that I must only take these products at the dose recommended.
I also understand that the dietary advice, nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that have been recommended are personalised for me and may not be suitable for another person.

It is my responsibility to inform Emily Stott and/or Ottawa Holistic Wellness immediately if I experience any unanticipated or unpleasant effects, including gastrointestinal upset (including but not limited to nausea, gas, stomach ache, vomiting) or allergic reactions (including but not limited to hives, rashes, tingling of the tongue, headache) which may be associated with the recommendations of Emily Stott.

In some cases the use of nutritional supplements and herbal products may cause interactions with pharmaceutical drugs, or be contra-indicated for certain medical / health conditions. I understand that it is my responsibility to keep all of my healthcare providers fully informed about all medications and nutritional supplements, herbs, or other products I may be taking, and as soon as I become aware of them.
It is also my responsibility to provide Emily Stott complete details of any existing or new medical / health conditions as soon as I become aware of them, or if I become aware that I am pregnant.

I understand that results are not guaranteed. I do not expect Emily Stott to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to nutritional consultation and treatment by Emily Stott. I intend this consent form to cover the entire course of treatment, and I understand that I am free to withdraw my consent at any time.

Patient Name _____ Guardian Name: _____

Patient / Guardian Signature_____ Date: _____

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