# SEEDED NUTRITION

## INITIAL INTAKE & CONSENT FORM

Thank you for taking the time to fill out this form. Please do your best to provide as much information and detail as possible. All information you provide is very important in the assessment of your case and is kept secure and confidential at all times.

Name:_____
Date:_____

Address:
_____

City:_____ Province:_____ Postal Code:_____

Email:_____
Phone:_____(H/W/C)

Sex:_____ Age:_____ Date of Birth:_____
Birthplace:_____

Who were you referred by/ how did you find us? :_____

1. **Why did you choose to come to SEEDED NUTRITION? Or seek a holistic nutritionist?**

_____
_____

2. **What do you know about holistic nutrition and SEEDED NUTRITION'S approach?**

_____
_____
_____

3. **What expectations do you have from your initial visit with Sherry?**

_____
_____

4. **What long term expectations do you have?**

_____
_____

5. **What expectations do you have of me personally as your holistic nutritionist and health consultant?**

_____
_____
_____

6. **What are your main health concerns/complaints? Please list in priority:**

**1)**_____**Date Started:**_____
**2)**_____**Date Started:**_____
**3)**_____**Date started:**_____

7. What are your main health *goals*? List your health goals from most important to least:

   1)_____
   _____

   2)_____
   _____

   3)_____
   _____

8. Do you have a family doctor or a primary healthcare provider? Y N
9. Clinic & Doctor's Name: _____
10. Phone:_____ Email:_____
    Date of your last physical exam or visit:_____
    Your Weight:_____ Your Height:_____ Blood Type:_____
    Have you ever been medically diagnosed for any condition(s)? Y N (if yes, what condition(s) and when were you diagnosed?):
    _____

11. Please list in detail any physical and emotional trauma you have experienced since birth:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list in order of appearance from your birth: <u>all</u> hospitalizations, surgeries, diseases, accidents, traumas and scars (<u>emotional</u> and physical). If you need more space please list on the back.

Age:_____
Age:_____
Age:_____
Age:_____
Age:_____
Age:_____
Age:_____
Age:_____
Age:_____
Age:_____

12. What forms of therapy or holistic modalities are you presently working with?

_____
_____

What forms of therapy and holistic modalities have you worked with in the past 10 years? Please include types of therapies that you feel have not worked for you in the past, and ones that you feel work well:_____
_____
_____

**13. What is your present level of commitment in addressing your health concerns while working with me?**
Rate from 0 to 10, 10 being 100% committed: 1 2 3 4 5 6 7 8 9 10

**14. What behaviours or lifestyle habits do you currently engage in that you believe support your health?**

_____
_____
_____

**15. What behaviours or lifestyle habits do you currently engage in that you believe detract from your health?**

_____
_____

**16. What potential obstacles do you foresee in addressing your health goals and following a health plan?**

_____
_____

**17. Who will sincerely support you in this process?**

_____
_____

**18. What do you LOVE to do? List the top 3 things you absolutely LOVE to do, what brings you true joy?**

_____
_____
_____

**19. What are your hobbies and interests?**

_____
_____
_____

**20. What are your personal dreams and aspirations? No matter how crazy you think they are:**

_____
_____
_____
_____

**21. How many hours do you sleep daily? _____Do you nap daily? Y N (how long)_____**

**22. What time do you go to sleep?_____ Awaken? _____**

**23. Do you have trouble falling asleep? Y N Staying Asleep? Y N If yes, reason?_____**

**24. Do you wake up in the middle of the night? Y N (please indicate the time you usually wake up)_____**

**25. Do you use any electronic devices before or up to 1 hour before bed? Y N (if yes please indicate type of electronic and nature of usage)_____**

**26. Do you awaken feeling rested? Y N Do you snore? Y N**

**27. What is your occupation?**

_____

**28. Do you enjoy your work? Y N Sometimes**

**29. How many hours do you work/day? _____ What times do you start/end your work?**

_____

30. Do you work shifts or are you on a regular schedule?

_____

31. Do you smoke? Y N If so, what brand? How often? And for how long have you been smoking?

_____

32. Does anyone in your household or workplace smoke? Y N How much? _____

33. How many hours on average do you spend daily: driving_____ watching tv_____ reading_____ in front of computer/smart device_____ spending outdoors_____ spending indoors_____

34. What level of stress do you feel you are experiencing on a daily basis? Rate from 0 to 10, 10 being extremely high: 1 2 3 4 5 6 7 8 9 10

35. What are your stress triggers?

_____

_____

How does your stress manifest itself?

_____

36. Rate your energy levels – from 0 to 10, 10 being high energy level:

1 2 3 4 5 6 7 8 9 10

37. Do you experience any lulls or highs in your energy levels throughout the day? If so, what time of day? Please describe:

_____

38. Do you use any coping mechanisms? Y N (if yes please list below what coping mechanisms you use):

_____

39. Do you feel you manage your stress? Y N (if yes, how do you usually manage stress?):

_____

40. What do you feel are the major causes of stress that you experience? Please quantify on a scale of 1 to 10, 10 being very high stress. Rate all that apply to you: Financial_____ Career_____ Marriage_____ Health_____ Family_____ Spiritual/Religious_____ Unfulfilling expectations_____ Self Image_____ Personal_____ Spouse/Partner_____ Relationships (please elaborate)_____ Other (please elaborate)_____

41. Do you vacation regularly? Y N When was your last vacation?_____

42. Do you regularly take "me time" or "unplug" from routines, work, and obligations? Y N (If yes, what are some of the things you do to take time to yourself and unplug from your daily obligations?

_____

_____

43. How often do you have a bowel movement?_____Do you strain? Y N Occasionally

44. Do you have loose stools? Y N Occasionally

45. Is there undigested food in your stool? Y N Occasionally

46. How do you feel before and after a bowel movement?

_____

## FEMALES:

1. Are you or could you be pregnant? Y N
2. Have you noticed any changes in menses, for example the frequency, durations, flow, clotting, scent, colour, or any other changes? Y N If yes please elaborate in detail:

   _____
   _____
3. Do you suffer from PMS symptoms? Y N Post-menopausal? Y N
4. Briefly describe your monthly menstrual cycle, for example do you get emotional? Angry? Are you in pain? Is it the same every month or do you experience changes? What are some of the common experiences you have?

   _____
   _____
   _____
5. Are you experiencing any menopausal symptoms? Y N If yes please specify:

   _____
6. Do you have frequent yeast infections? Y N
7. Have you ever had a fungal infection (eg: Candidiasis)? Y N If yes, please describe the infection, when, and how it was treated?

   _____
   _____
   _____

## MALES:

1. Have you experienced any prostate problems (eg: frequent urination, discomfort during urination? Y N Please describe in detail: _____
2. Have you experienced fungal infections (eg: jock itch, athlete's foot, toe fungus, candidiasis) Y N
3. Have you experienced a decline in sexual interest? Y N If yes, please describe in detail: _____
4. Have you had kidney or gall stones? Y N How many?_____ When?_____ How often?_____

Marital Status: _____ No. in living space: _____
No. of children & ages:_____
Occupation/Role: _____
Past occupations: _____
Retired? Y N If yes, when? _____
Please tell me a bit about your religion and your personal philosophy:
_____
_____
_____
_____

## MEDICAL HISTORY:

1. Are you currently seeking treatment for any medical condition? Y N If yes, what condition(s)?
   _____

2. What medication(s) have you been prescribed for the condition(s)?
   _____
   _____

Please fill in the following information about any *current* medications or supplements you are taking:

| MEDICATION | DOSE | HOW OFTEN | FOR HOW LONG | REASON |
|---|---|---|---|---|
| | | | | |
| **SUPPLEMENT** | **DOSE** | **HOW OFTEN** | **FOR HOW LONG** | **REASON** |
| | | | | |

3. Have you ever had bad reactions to medications or supplements?_____
4. How many courses of antibiotics have you had in the past 10 years? _____
5. Please list all allergies or sensitivities (food, environment, medications):
   _____
   _____
6. Have you ever been hospitalized? Y N For what reason? _____
7. Have you had surgery to remove any of the following: Gall bladder Tonsils Appendix Other_____
8. Have you had a bone density test? Y N Results: _____

9. **Do you have the following?** *Internal pins* *Artificial joints* *Pacemaker*
*Transplant* *Implant* *Wires* **Where and when were they placed?**

_____

10. **Which of the following relates to your dental history?** Please circle all that apply

*silver fillings/ white fillings/ gold fillings* *root canals* *caps* *dentures* *partials/tooth extracts*

11. **How many fillings do you have?** Silver fillings_____ White fillings_____ Gold fillings_____

## Most recent medical procedures & blood tests:

| **Procedure** (pls circle) | **Abnormal?** | **Date** | **Blood Tests** (pls circle) | **Abnormal?** | **Date** |
|---|---|---|---|---|---|
| Sigmoidoscopy/Colonoscopy | ☐ | _____ | Complete Blood Count | ☐ | _____ |
| MRI / CT Scan | ☐ | _____ | Cholesterol Panel | ☐ | _____ |
| Bood/ Plasma Transfusion | ☐ | _____ | Liver Enzymes | ☐ | _____ |
| Pap Smear | ☐ | _____ | Thyroid Panel | ☐ | _____ |
| Mammogram | ☐ | _____ | Fasting blood glucose | ☐ | _____ |
| Digital Rectal Exam/ PSA | ☐ | _____ | Hormone Panel | ☐ | _____ |
| EKG/ EEG | ☐ | _____ | Other:_____ | ☐ | _____ |

**X-ray of:** Teeth Stomach/gallbladder Chest Colon Extremities Other: _____

## DIETARY HABITS:

**How many times a day do you eat?**
**Main meals**_____**Times of day:** _____
**Snacks** _____**Times of day:** _____
**Other info you feel is important regarding your frequency of meals:**
_____
**Do you eat meals....** With family Home alone On the run Restaurant Fast food
Other:_____

**Do you feel there are restrictions to your diet due to preferences or influences of others? Y N**
**If yes, please explain:**
_____
**Are you on a restricted diet now? Y N Please specify which diet and why:**
_____
_____

**How many servings of each do you typically eat per day? *Please circle***
**Fruit:** I don't eat fruit 1/4cup 1/2cup 1cup 1.5cups 2cups 2.5cups
other_____
**Vegetables:** I don't eat veggies 1/4cup 1/2cup 1cup 1.5cups 2cups 2.5cups
other_____
**Whole grains:** I don't eat grains 1/4cup 1/2cup 1cup 1.5cups 2cups 2.5cups
other_____

**Protein** ***(1 steak or chicken breast has approx 25g of protein. 1 cup of cooked lentils or chickpeas has approx 15g*****):**
I don't eat protein  20 grams or less  20-30 grams  30-50 grams  50-75 grams  75+ grams
**Please specify the type of protein you typically eat:**

_____

**Dairy products:** don't eat dairy  1/4cup or less  1/2cup  1cup  1.5cups  2cups  2+ cups
Other:_____
**Please specify type of dairy you typically eat and brand:**

_____

**Processed meats/cold cuts/sausage/bacon:** don't eat processed meats  50g or less  50-150g  150+ g

**Packaged foods:**
I don't eat packaged foods ☐  Some packaged foods are incorporated in my meals ☐
Only my snacks are packaged foods ☐  At least one meal is packaged ☐
2 of my meals are packaged ☐  3 or more meals are packaged ☐

**Provide examples of your typical meals:**
***Breakfast:***

_____
_____

***Lunch:***

_____
_____

***Dinner:***

_____
_____

***Snacks:***

_____

**Please rate your usage or intake (indicate 1 for rarely, 2 for regularly, 3 for often):**

| | | | |
|---|---|---|---|
| Aluminum pans_____ | Margarine_____ | Candy_____ | Microwave_____ |
| Teflon pots/pans_____ | Fast foods_____ | Fried foods_____ | Packaged foods_____ |
| Chocolate_____ | Luncheon meats_____ | Junk food_____ | |
| Corn (in any form)_____ | Soy (in any form)_____ | Artificial colours/Food colouring_____ | |
| Fermented foods_____ | | | |

**Please answer the following as it best describes you:**

| | | | | |
|---|---|---|---|---|
| Drink water | Y | N | glasses/day _____ | Source(s) of water _____ |
| Drink Coffee | Y | N | glasses/day _____ | |
| Drink Tea | Y | N | glasses/day _____ | Kind(s) of tea _____ |
| Drink pop/soda | Y | N | glasses/day _____ | Brand _____ |
| Drink wine/alcohol | Y | N | glasses/day _____ | Kind of alcohol _____ |
| Smoke tobacco | Y | N | cigarettes/day _____ | Kind of cigarettes _____ |
| Smoked in past | Y | N | cigarettes/week ____ | How many years _____ |
| Recreational drugs | Y | N | times/week _____ | Kind of drug(s) _____ |
| Drug use in past | Y | N | How many years _____ | |
| Exposed to allergens | Y | N | hours/week _____ | Type(s) of toxins _____ |
| Use artificial sweeteners | Y | N | packages/day _____ | Which sweetener _____ |
| Chew gum/tobacco | Y | N | pieces/day _____ | |
| Eat seafood (tuna/sword/shark) | Y | N | servings/week _____ | What kind of fish _____ |
| Eat processed/packaged foods | Y | N | servings/day _____ | What kind _____ |
| Use of antiperspirant | **Y** | **N** | brand _____ | |

## CHILDHOOD ILLNESSES (please circle):

**Eczema Ear Infections Chickenpox Mononucleosis Measles Mumps**
**Scarlet fever Whooping Cough Diphtheria Meningitis Tonsillitis Pneumonia**
**Other:**_____

## FAMILY HISTORY:

**Please check which diseases apply to any blood relative:**

| *Please Circle* | Mother | Father | Sibling | Child | Grandparents | Others |
|---|---|---|---|---|---|---|
| Cancer (type?) | | | | | | |
| Hereditary Disease (type?) | | | | | | |
| Skin Disease/Conditions (type?) | | | | | | |
| Heart Disease/ Stroke | | | | | | |
| Hypertension | | | | | | |
| Arthritis/Gout/Osteoporosis | | | | | | |
| Kidney Disease | | | | | | |
| Lung Disease/Asthma/TB | | | | | | |
| Liver Disease/ Cirrhosis | | | | | | |
| Hypoglycemia/Diabetes | | | | | | |
| High blood sugar/High Cholesterol | | | | | | |
| Mental Illnesses/Epilepsy | | | | | | |
| Miscarriages | | | | | | |
| Syphilis/ Gonorrhea/HIV | | | | | | |
| Drug Abuse/ Addiction/ Alcoholism | | | | | | |
| Autoimmune Disorders (type?) | | | | | | |
| Intestinal/ Gastrointestinal Diseases | | | | | | |
| Thyroid Problems/Obesity | | | | | | |
| Gallbladder Issues | | | | | | |

Other diseases_____

Is there anything else you feel inclined to share with me? For example: memories or certain experiences that stand out, dreams/repetitive dreams that stand out, repetitive or unusual illnesses or symptoms, habits, life shifts, epiphanies, interesting life events that stand out or you don't understand, feelings or emotions you are wiling to share regarding yourself, or our work together, etc…

**What other information do you feel can further help me in your assessment?**