Please fill out and fax these forms to 720-420-9561 at least 24 hours before your scheduled appointment.

Disclaimer of Liability

I, the undersigned, agree to accept and pay for nutrition consultation services (aka health coaching) offered to me by Nutrition Inc. I also accept and understand the following:

- Nutrition therapy services may include guidance on healthy food choices, eating habits, physical activity, dietary supplementation, and/or lifestyle changes. Recommendations given by a nutrition therapist are not intended to diagnose, treat, cure, prescribe, or act as a substitute for medical care. Nutrition therapists will not recommend the discontinuation of a course of medical care recommended by a health care professional.
- While people generally experience greater health and wellness as a result of embracing a healthier attitude, lifestyle, and diet, nutrition therapy does not promise or guarantee protection from future illness. Participants should discuss recommendations with their physician.
- Participation in private consultation with a nutrition therapist is voluntary. Information shared during private consultations is confidential and will not be shared with the employer or other third parties unless permitted by the employee in writing or unless required by law.
- The State of Colorado does not license, certify, or register Master Nutrition Therapists as health care professionals. All Nutrition Inc. nutrition therapists have obtained Nutrition Therapy Practitioner and Master Nutrition Therapist designations through the Nutrition Therapy Institute in Denver, Colorado. Nutrition Inc. carries professional liability insurance
- By signing below, you acknowledge that you understand that a nutrition therapist is a health consultant and not a physician, and that you should see a doctor if you think you have a medical condition. Nutrition Inc. will not be held liable for failure to diagnose or treat an illness, nor will Nutrition Inc. be liable for failure to prevent future illness.

Client name (print) ____

Signature ____ Date _____________

Parent signature if client is under 18 ____
*Parent must be present during child consultation.

Mailing Address ____

Employer ____

Phone ________________________ Email ___________________________________

Please retain a copy of this form for your records.

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CLIENT INFORMATION

Name:	**Company:**
Address/City/State/Zip:	
Best Phone Number:	
E-mail Address:	
Date of Birth: **Age:** ☐ Male ☐ Female	**Relationship Status:**
Children & Ages:	
Height: **Weight:**	**Occupation:**
Why are you seeking nutrition consultation?	
What are your major health concerns?	

VITAMINS AND SUPPLEMENTS: *Please list the vitamins and supplements you are taking*

Supplement	Dosage (if known)	Reason	Time of Day

MEDICATIONS: *Please list the medications you are taking (prescription or over-the-counter)*

Drug	Dosage (if known)	Reason	Time of Day

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Symptoms Survey

Please check the appropriate number on all questions below with

0 being the least/never to 3 being the most/always.

Category I

Diarrhea………………………….	☐0	☐1	☐2	☐3
Constipation……………………..	☐0	☐1	☐2	☐3
Coated tongue of "fuzzy" debris on tongue………………….	☐0	☐1	☐2	☐3
More than 3 bowel a day ………	☐0	☐1	☐2	☐3
Excessive belching, burping, or bloating………………………	☐0	☐1	☐2	☐3
Difficult bowel movements…….	☐0	☐1	☐2	☐3
Undigested foods in stools……	☐0	☐1	☐2	☐3
Stomach pain, burning, or aching 1- 4 hours after eating….	☐0	☐1	☐2	☐3
Use antacids……………………	☐0	☐1	☐2	☐3
Get relief from antacids, food, milk, carbonated beverages…….	☐0	☐1	☐2	☐3
Roughage/fiber cause constipation	☐0	☐1	☐2	☐3
Excessive passage of gas…….	☐0	☐1	☐2	☐3
Nausea and/or vomiting……….	☐0	☐1	☐2	☐3
Mucous in stool……………….	☐0	☐1	☐2	☐3

Category II

Greasy or high-fat foods make you uncomfortable…………………..	☐0	☐1	☐2	☐3
Stool color alternates from clay colored to normal brown…..	☐0	☐1	☐2	☐3
History of gallbladder attacks or stones…………………………	☐0	☐1	☐2	☐3

Have you had your gallbladder removed? ☐Y ☐N

Category III

Crave sweets/coffee during day……	☐0	☐1	☐2	☐3
Irritable, shaky or lightheaded if meals are missed………………	☐0	☐1	☐2	☐3
Fatigue after meals……………..	☐0	☐1	☐2	☐3
Afternoon Fatigue ……………..	☐0	☐1	☐2	☐3
Eating relieves fatigue …………	☐0	☐1	☐2	☐3
Frequent urination………………	☐0	☐1	☐2	☐3
Increased thirst and appetite…..	☐0	☐1	☐2	☐3

Category IV

Cannot stay asleep………………	☐0	☐1	☐2	☐3
Crave salt…………………………	☐0	☐1	☐2	☐3
Slow starter in the morning……..	☐0	☐1	☐2	☐3
Afternoon fatigue or headaches..	☐0	☐1	☐2	☐3
Cannot fall asleep………………	☐0	☐1	☐2	☐3
Perspire easily……………………	☐0	☐1	☐2	☐3
Under high amounts of stress…..	☐0	☐1	☐2	☐3

Category V

Tired, sluggish……………………	☐0	☐1	☐2	☐3
Feel cold – hands, feet, all over..	☐0	☐1	☐2	☐3
Hair loss…………………………..	☐0	☐1	☐2	☐3
Difficulty gaining or losing weight (circle one)	☐0	☐1	☐2	☐3
Depression, lack of motivation….	☐0	☐1	☐2	☐3
Mental sluggishness ……………	☐0	☐1	☐2	☐3
Heart palpitations or inward trembling …………………………	☐0	☐1	☐2	☐3
Nervous and emotional …………	☐0	☐1	☐2	☐3
Night sweats ……………………	☐0	☐1	☐2	☐3

Category VI – for Males

Sweating attacks…………………	☐0	☐1	☐2	☐3
More emotional than in the past	☐0	☐1	☐2	☐3
Episodes of depression………..	☐0	☐1	☐2	☐3
Urination difficulty …………….	☐0	☐1	☐2	☐3

Category VII – for Females

Are you perimenopausal/postmenopausal? (circle one) ☐Y ☐N

Do you have PMS Symptoms? ☐Y ☐N

How is your flow? ☐Light ☐Med ☐Heavy

Facial hair growth ………………	☐0	☐1	☐2	☐3
Acne breakouts…………………	☐0	☐1	☐2	☐3
Episodes of depression………..	☐0	☐1	☐2	☐3

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Day 1 Time:	**FOOD**	**DRINK**	**OBSERVATIONS** (include such things as digestive discomfort, pain, fatigue, cravings)	**ENERGY** (high, medium, low)
Example 7am	*Yogurt w granola, banana*	*Water, OJ*	*Tired, slight upset stomach after eating*	☐H ☐M ☒L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L

Describe your activities today

____

____

____

Glasses of water (8oz) you drank today (circle)

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Day 2 Time:	**FOOD**	**DRINK**	**OBSERVATIONS** (include such things as digestive discomfort, pain, fatigue, cravings)	**ENERGY** (high, medium, low)
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L

Describe your activities today

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____

Glasses of water (8oz) you drank today (circle)

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Day 3 Time:	FOOD	DRINK	OBSERVATIONS (include such things as digestive discomfort, pain, fatigue, cravings)	ENERGY (high, medium, low)
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L

Describe your activities today

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Glasses of water (8oz) you drank today (circle)

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Day 4 Time:	**FOOD**	**DRINK**	**OBSERVATIONS** (include such things as digestive discomfort, pain, fatigue, cravings)	**ENERGY** (high, medium, low)
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L
				☐H ☐M ☐L

Describe your activities today

____

____

____

Glasses of water (8oz) you drank today (circle)

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