

INTAKE FORMS

Name _____ Ht. _____ Wt. _____ DOB _____

Address _____ City _____

State _____ Zip _____ Phone _____ Date _____

E-mail Address _____

Who can we thank for referring you? _____

Occupation (describe) _____ Full Time _____ Part Time _____

How many Pregnancies? _____ How many children? _____

ON A SEPARATE PAPER, PLEASE WRITE DOWN A 3 DAY DETAILED FOOD DIARY

What are your main health concerns? _____

List any major illness or surgeries you have had: _____

List any health problems in your immediate family _____

What do you feel is your energy level on a scale of 1-10 (10 best)? _____

What is your blood type? _____

When was your last physical? _____ Your last blood test showed _____

Glucose level _____ Cholesterol _____ HDL _____ LDL _____ Triglycerides _____

Males do you have any prostate problems? _____ When was last test? _____

Females do you have problems with PMS _____ Menopause? _____

Other female problems? _____

Are you on any medication? _____ If so, what kind? _____

How often do you exercise? _____ Type _____

How many hours do you sleep at night? _____ Do you feel rested? _____

How much water do you drink each day? _____ What kind? _____

Do you skip meals often? _____ Breakfast _____ Lunch _____ Dinner _____

Do you have a history of dieting? _____

What are your favorite snacks? _____

TOXICITY SELF TEST

Rate each of the following symptoms based upon your typical health profile for:

- POINT SCALE**
- 0 = Never or almost never have the symptom
 - 1 = Occasionally have it, effect is not severe
 - 2 = Occasionally have it, effect is severe
 - 3 = Frequently have it, effect is not severe
 - 4 = Frequently have it, effect is severe
-

HEAD _____ Headaches
 _____ Faintness
 _____ Dizziness
 _____ Insomnia
Total _____

EYES _____ Watery or itchy eyes
 _____ Swollen, reddened or sticky eyelids
 _____ Blurred or tunnel vision (does not include near or farsightedness)
Total _____

EARS _____ Itchy ears
 _____ Earaches, ear infections
 _____ Drainage from ear
 _____ Ringing in ears, hearing loss
Total _____

NOSE _____ Stuffy nose
 _____ Sinus problems
 _____ Hay fever
 _____ Sneezing attacks
 _____ Excessive mucus formation
Total _____

MOUTH/ _____ Chronic coughing
THROAT _____ Gagging, frequent need to clear throat
 _____ Sore throat, hoarseness, loss of voice
 _____ Swollen or discolored tongue, gums, lips
 _____ Canker sores
Total _____

SKIN _____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating Total_____

HEART _____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain Total_____

LUNGS _____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing Total_____

DIGESTIVE TRACT _____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloating feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain Total_____

JOINTS/ _____ Pain or aches in joints
MUSCLE _____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness Total_____

WEIGHT _____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight Total_____

ENERGY/

ACTIVITY _____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
Total _____

MIND _____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total _____

EMOTIONS _____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
Total _____

OTHER _____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total _____

GRAND TOTAL **TOTAL** _____

What vitamins and minerals do you take? (Please bring with you)

SIGNS OF FATTY ACID IMBALANCE

Fatty acid imbalance can manifest in many different ways and may affect almost any body system. However, there is set of signs and symptoms that are correlated with fatty acid imbalance.

Do you have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Brittle easily frayed nails |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Patches of pale skin on cheeks |
| <input type="checkbox"/> Dry, unmanageable hair | <input type="checkbox"/> Alligator skin |
| <input type="checkbox"/> Lowered immunity | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Soft nails |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Learning problems |
| <input type="checkbox"/> “Chicken skin” on backs of arms | <input type="checkbox"/> Attention deficit |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Cracked Skin on heels or fingertips |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Excessive earwax |
| <input type="checkbox"/> Poor wound healing | |

What is your cholesterol? _____

Do you eat foods high in sugar? _____ never _____ seldom _____ often

Do you drink alcoholic beverages? _____ never _____ seldom _____ often

Do you eat fast foods? _____ never _____ seldom _____ often

Digestion problems? _____ Explain _____

Do you smoke? _____ How much? _____ Did you ever smoke _____

Are you under high, medium, or low stress? _____

What is your response to stress? _____

Do you have an inherited predisposition (atopy) to allergies, eczema, etc.? _____

Were you a breast fed baby? _____ Have you done fasting/starvation? _____

SYMPTOMS OF ALLERGIES AND SENSITIVITES

- Vomiting/spitting up
- Ear infections
- Itching in ears
- Dark circles under eyes
- Congestion/runny nose
- Coughing/wheezing
- Picky eater
- Seasonal allergies
- Hives/skin rashes/eczema
- Red earlobes/pink cheeks
- Chronic infections
- Headaches
- Sensitive
- Constipation/diarrhea
- Hyper/overactive
- Angry/hostile
- Distractible
- Fatigue
- Learning problems
- Had multiple antibiotics
- Food cravings
- Agitated/irritable after eating
- Sleepy after eating
- Seasonal behavioral changes
- Stomachaches
- Uncontrollable outbreaks

Are you exposed to any chemicals in your work or home environment?_____

If so, please explain_____

Do you have amalgams (mercury fillings) in your teeth?_____

Any present or past substance abuse?_____

What area of your diet needs improvement in your opinion?_____

Any additional comments:_____

Advanced Nutrition Center, Inc.

Functional Nutrition & Aging Smart

“Nothing taste as good as health feels”

“Seven out of ten leading causes of death in America are related to lifestyle habit.” -Surgeon General

CONSENT FORM

I, Sherrlyn Christmas-John am a health educator and nutrition consultant. As such, **I do not diagnose or treat disease.** Rather, **I support lifestyle balance, nutrition and health.**

(Please initial the following)

I, _____ understand that information provided on the relationship between nutrition, lifestyle factors and health is not meant to replace competent medical treatment for any health problem or condition.

I, _____ choose to improve my health by assuming greater self-responsibility to reduce or eliminate unhealthy behaviors that are contrary to my well-being.

I, _____ understand that I will be charged \$135 per hour for the initial consultation and thereafter, payable upon rendering services. Phone consultations will be charged at the same hourly rate.

I, _____ understand that canceled or missed appointments require a minimum 24 hour notification or I will be charged for the appointment.

I, _____ here certify that I am here solely on my own behalf. I am not representing any other person, company, association, and/or on behalf of any government agency.

I, _____ give permission to contact physicians to discuss, plan and to obtain medical records confidentially.

I _____ it is my understanding, when receiving a test kit or ordering lab work from Advanced Nutrition; my test results will not be released without an appointment for a proper assessment. Performing lab work prior to the 1st initial consultation is an extended favor to authorized clients only.

We agree to work together to design and maintain an individualized wellness program based upon reliable information, practical skills, feedback and support.

Signed _____
Client

Date _____

Print name _____

Signed _____
Sherrlyn Christmas-John, C.N.C.

Date _____