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/THROAT
_____Chronic coughing
_____ 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
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain Total_____

Joints/ Muscle
_____Pain or aches in joints
_____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?

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

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 $150 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 Center; 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 _____ Date_____

Client

Print name_____

Signed _____ Date_____

Sherrlyn Christmas-John, C.N.C.