real healing
NUTRITION

# HEALTH INTAKE FORM

First Name _____ Last Name _____

Email _____ Today's Date _____

Referred By (individuals name or company workshop) _____

Address _____

Phone _____ Age _____

Date of Birth _____ Height _____

Ethnic background/Birthplace _____

Current weight _____ Ideal Weight _____

Weight six months ago _____ Weight one year ago _____

Relationship Status _____ Pets _____

Children _____

Ages _____

Occupation _____

Previous occupation _____ When _____

How many hour a week do you work? _____

Do you enjoy your job/ daily activities? _____

Do you fall asleep well? _____ Stay asleep or wake up at night? _____

Energy level on a scale of 1-10?_____ Stress level on a scale of 1-10? _____

What is the biggest source of stress in your life? _____

Any serious illnesses as a child? _____

_____

Please list any past or current diseases or disorders that run in your family, with the family member affected _____

_____

PLEASE EMAIL YOUR COMPLETED FORM TO lindsay@realhealingnutrition.com

real healing
NUTRITION

HEALTH INTAKE FORM

## FOR WOMEN ONLY

Are your periods regular? _____

How many days is your flow? _____

How frequent? _____

Painful or symptomatic? _____

Any clotting? _____

Heavy or light flow? _____

Birth control pill history (please list total years) _____

Have you worn an IUD? _____ If yes, for how long? _____

If you no longer wear an IUD, when did you stop? _____

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____

Age when menstrual periods began _____

Lumps in Breast_____ Armpit _____ Groin Area _____

Hysterectomy? _____

If yes, when? _____

Have you gone through menopause or are you going through menopause?_____

If yes, when? _____

## FOR MEN ONLY

Lumps in groin area or just above and to the side of the penis? _____Yes _____ No

Has the quality of your orgasm, or force of release, diminished? _____Yes _____ No

Troubles concerning erection or ejaculation? _____Yes _____ No

Troubles or concerns with your libido? _____Yes _____ No

Troubles or concerns with the prostate? _____Yes _____ No

PLEASE EMAIL YOUR COMPLETED FORM TO lindsay@realhealingnutrition.com

real healing
NUTRITION

# HEALTH INTAKE FORM

**Have you had, or do you have...? (Please check yes or no. If yes, please indicate when)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Bloating | Yes ☐ | No ☐ | _____ | Blood in urine | Yes ☐ | No ☐ | _____ |
| Breasts tender | Yes ☐ | No ☐ | _____ | Hay fever | Yes ☐ | No ☐ | _____ |
| Cramping | Yes ☐ | No ☐ | _____ | Need to urinate frequently | Yes ☐ | No ☐ | _____ |
| Moodiness/Irritable | Yes ☐ | No ☐ | _____ | Urinate during night | Yes ☐ | No ☐ | _____ |
| Depression | Yes ☐ | No ☐ | _____ | Allergies (seasonal) | Yes ☐ | No ☐ | _____ |
| Anxiety | Yes ☐ | No ☐ | _____ | Trouble dealing with stress | Yes ☐ | No ☐ | _____ |
| Highly emotional | Yes ☐ | No ☐ | _____ | Burning when you urinate | Yes ☐ | No ☐ | _____ |
| Mental Fogginess | Yes ☐ | No ☐ | _____ | Sinus trouble | Yes ☐ | No ☐ | _____ |
| Migraines | Yes ☐ | No ☐ | _____ | Kidney or bladder stones | Yes ☐ | No ☐ | _____ |
| Low back pain | Yes ☐ | No ☐ | _____ | Mental Fogginess | Yes ☐ | No ☐ | _____ |
| Neck/Shoulder pain | Yes ☐ | No ☐ | _____ | Goiter | Yes ☐ | No ☐ | _____ |
| Dizzy spells | Yes ☐ | No ☐ | _____ | Protein in albumin in urine | Yes ☐ | No ☐ | _____ |
| Water retention | Yes ☐ | No ☐ | _____ | Trouble starting urine stream | Yes ☐ | No ☐ | _____ |
| Acne/Skin outbreaks | Yes ☐ | No ☐ | _____ | Mucous in chest | Yes ☐ | No ☐ | _____ |
| Joint pain | Yes ☐ | No ☐ | _____ | Urinary infections | Yes ☐ | No ☐ | _____ |
| Brittle nails | Yes ☐ | No ☐ | _____ | Venereal disease or Herpes | Yes ☐ | No ☐ | _____ |
| Cold Hands/Feet | Yes ☐ | No ☐ | _____ | Jaundice, hepatitis or mono | Yes ☐ | No ☐ | _____ |
| Thinning hair | Yes ☐ | No ☐ | _____ | Shortness of breath | Yes ☐ | No ☐ | _____ |
| Fever or chills | Yes ☐ | No ☐ | _____ | High blood pressure | Yes ☐ | No ☐ | _____ |
| Night sweats | Yes ☐ | No ☐ | _____ | Heart trouble | Yes ☐ | No ☐ | _____ |
| Asthma | Yes ☐ | No ☐ | _____ | Fast, irregular or slow pulse | Yes ☐ | No ☐ | _____ |
| Frequent headaches | Yes ☐ | No ☐ | _____ | Pain in chest | Yes ☐ | No ☐ | _____ |
| Diarrhea | Yes ☐ | No ☐ | _____ | Varicose veins | Yes ☐ | No ☐ | _____ |
| Constipation | Yes ☐ | No ☐ | _____ | Frequent colds or flu | Yes ☐ | No ☐ | _____ |
| Periods of unconsciousness | Yes ☐ | No ☐ | _____ | Black bowel movements | Yes ☐ | No ☐ | _____ |
| Frequent indigestion | Yes ☐ | No ☐ | _____ | Hypoglycemia | Yes ☐ | No ☐ | _____ |
| Gas | Yes ☐ | No ☐ | _____ | Arthritis or bursitis | Yes ☐ | No ☐ | _____ |
| Complete or partial blindness | Yes ☐ | No ☐ | _____ | Nervous breakdown | Yes ☐ | No ☐ | _____ |
| Hearing trouble | Yes ☐ | No ☐ | _____ | Skin rashes | Yes ☐ | No ☐ | _____ |
| Eye trouble | Yes ☐ | No ☐ | _____ | Is your appetite good | Yes ☐ | No ☐ | _____ |
| Burning when you urinate | Yes ☐ | No ☐ | _____ | Do you feel rested | Yes ☐ | No ☐ | _____ |
| Ulcer of stomach | Yes ☐ | No ☐ | _____ | Do you feel tired after eating | Yes ☐ | No ☐ | _____ |
| Cough | Yes ☐ | No ☐ | _____ | No energy during the day | Yes ☐ | No ☐ | _____ |
| Blood in bowel movements | Yes ☐ | No ☐ | _____ | Swollen lymph glands | Yes ☐ | No ☐ | _____ |

PLEASE EMAIL YOUR COMPLETED FORM TO lindsay@realhealingnutrition.com

real healing
NUTRITION

# HEALTH INTAKE FORM

How is your digestion? Any constipation / diarrhea/ gas? _____

How many times do you eliminate daily? _____

Antibiotic history (how often) _____

Other long-term prescription or over the counter drug use? _____

Any known problems with your thyroid? _____ Last time you had it tested? _____

Yeast infections common? _____

Last Cholesterol reading and date? _____

Last blood pressure reading _____

Blood type? _____

Please list any hospitalizations / injuries _____

Any current or past diseases, viruses or infections? _____

**Please list current supplements and medications:**

Vitamins/Food Based _____

Prescription _____

Other over the counter meds _____

Are there any other healers, helpers or therapies with which you are involved? (acupuncture, massage, therapy, energy work, chiropractic care, etc) Please list all

_____

What role does exercise or movement play in your life? (please explain)

_____

Do you follow a regular awareness practice? (mediation, prayer, affirmation, etc)

_____

Frequency and importance in your life _____

Use a microwave? If so, how often? _____

PLEASE EMAIL YOUR COMPLETED FORM TO lindsay@realhealingnutrition.com

real healing
NUTRITION

HEALTH INTAKE FORM

Aluminum or Teflon cookware? _____

Do you drink coffee? If so, how many ounces per day? _____

What do you put in it? _____

Do you drink soda or sparkling water? If so, how often and what kind? _____

Alcohol? If so, how many drinks per week and what type of alcohol? _____

Do you smoke? If so, how often? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions?

_____

What percentage of your food is home cooked? _____

Where do you get the rest from? _____

Do you enjoy cooking? _____ Who does the cooking in your household? _____

**Please list your chief health concerns/health goals, physical, mental, emotional or spiritual.**

Concern #1 _____

Concern #2 _____

Concern #3 _____

Goal #1 _____

Goal #2 _____

Goal #3 _____

The most important thing I should do to improve my health is? _____

How is the health of your mother? Please explain _____

How is the health of your father? Please explain _____

What foods did you eat as a child? _____

Was food a positive experience for you growing up? If no, please explain

_____

real healing
NUTRITION

# HEALTH INTAKE FORM

**Please list what you usually eat for**

Breakfast _____

Mid Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Desserts _____

Liquids _____

How many ounces of water do you drink daily? _____

What kind of water? _____

Has your eating changed much in the past year? If so, how? _____

Is your diet mostly cooked, raw or a combination? _____

**Check if you like**

☐ Spicy ☐ Bitter ☐ Salty ☐ Sweet ☐ Sour

Do you buy organic? If so, which foods? _____

On a scale of 1-10 (10 being the greatest), how motivated are you to improve your health? ____

Disclaimer of Health Care Related Services:

*Any advice given should never be used as a substitute for the medical advice from your own doctor. Always consult your own Medical Doctor (M.D.) if you are concerned about your health. Your Counselor/Nutritionist is not acting in the capacity of a doctor, psychologist or other licensed or registered professionals. Additionally your Counselor/Nutritionist will not provide health care or medical services and will not diagnose any disease, prescribe, or treat symptom, defect, injury or disease. This appointment is for educational purposes only.

*Any discussion regarding vitamins or other supplements should always be communicated with your GP before use.

If the terms of this Agreement are acceptable, please sign the acceptance below. Thank you and we appreciate the opportunity to work with you.

_____ _____

Signature Date

PLEASE EMAIL YOUR COMPLETED FORM TO lindsay@realhealingnutrition.com

real healing
NUTRITION



# AGREEMENT AND UNDERSTANDING PRIOR TO CONSULTATION WITH:

Lindsay A Sherry, C.H.H.C

Prior to retaining the services of Lindsay Sherry, C.H.H.C., I certify that I clearly understand the following:

I, _____, the undersigned, do hereby acknowledge that Lindsay Sherry states to me that she is a Nutrition and Certified Holistic Health Counselor and that she is not a licensed (allopathic) medical doctor (M.D.) or licensed primary health care provider.

I state that I come to Mrs. Sherry with the purity of purpose of seeking more information. I state that I do not come with any forethought or desire for entrapping Mrs. Sherry into an illegal statement. If I am a member of the AMA, the F.D.A., or any law enforcement agency, or any city, county, state or federal regulatory agency, then I will identify myself a such before the appointment begins.

I understand Mrs. Sherry's sole intention is to offer to me general educational information I request. If I choose to use this information to work on myself, then I affirm that the responsibility is mine. I affirm my right to self-health and I take full responsibility for my healing process.

I understand Mrs. Sherry to state that I or anyone should never use her information in any way that contradicts, conflicts, or opposes a course of treatment recommended by a primary health care provider such as a licensed medical doctor. If I ever perceive or feel that information given by Mrs. Sherry opposes a licensed doctor's treatment or recommendations, Mrs. Sherry strongly advises me to follow the advice and instruction of my licensed primary health care provider.

I, the undersigned, do hereby voluntarily state to understand and acknowledge as accurate all the above comments.

Date _____ Signature _____

Name _____

Address _____

_____

Telephone:(hm) _____

(wk) _____

PLEASE EMAIL YOUR COMPLETED FORM TO lindsay@realhealingnutrition.com