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Dynamic by Nature

FUNCTIONAL NUTRITION – NEW CLIENT INTAKE FORM
CONFIDENTIAL

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PLEASE CHECK BOXES, CIRCLE OR FILL IN WHERE APPLICABLE
To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information will be kept confidential in your file.

FULL NAME

DATE OF BIRTH

GENETIC BACKGROUND European

IF OTHER, SPECIFY

JOB TITLE

NATURE OF BUSINESS

ADDRESS

PHONE (HOME)

PHONE (CELL)

CITY

EMAIL

PROVINCE BC **POSTAL CODE**

PREFERRED CONTACT METHOD

◯ Text Message ◯ Email

EMERGENCY CONTACT NAME

EMERGENCY CONTACT PHONE (CELL)

PRIMARY CARE PHYSICIAN

Are you currently working with any alternative practitioners? If so, please identify (check all that apply):

☐ Naturopath ☐ TCM Doctor ☐ Osteopathic Practitioner ☐ Herbalist

Other (specify) Referred by

Please list your current and existing complaints according to their priority level (describe problem in detail):

1.

2.

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3.

Please specify any **allergies** you are aware of (environment, food, supplements, medications) and specific reactions:

1.

2.

3.

MEDICAL HISTORY

Have you ever been diagnosed with a dysfunction in any of the systems listed below? If so, please specify.

- Gastrointestinal
- Cardiovascular
- Metabolic or Endocrine
- Cancer
- Reproductive or Genital
- Urinary or Bladder
- Musculoskeletal
- Inflammatory
- Autoimmune
- Respiratory
- Skin
- Mental, Emotional or Neurological

Specify ailment and diagnoses:

Please list any injuries you may have sustained:

Hospitalizations:

Surgeries:

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What was your birth process like?

Normal Premature Caesarean Any difficulties?

Women's Reproductive Disorders or Hormonal Imbalances Yes No N/A
Please describe issue:

Men's Hormonal Imbalances, Prostate Issues or Erectile Dysfunction Yes No N/A
Please describe issue:

GI History (foreign travel, wilderness camping, severe diarrhea or parasites): Yes No
Please specify issue:

Current Pharmaceutical Medications (please list):

1. **4.**

2. **5.**

3. **6.**

Current Nutritional Supplements (please list):

1. **4.**

2. **5.**

3. **6.**

Current Herbs or Homeopathy (please list):

1. **4.**

2. **5.**

3. **6.**

Have you ever had prolonged or regular use of Anti-Depressants, Anti-Inflammatories, Antacids, Steroids, or Antibiotics (> 3x's per year)? Yes No

If yes, please specify which medication, and describe length or use and any side effects

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NUTRITION & EATING HABITS

Do you currently follow a special diet or nutrition program? If so, check all that apply:

- Vegetarian
- Vegan
- Diabetic
- Keto
- High Protein
- Dairy-free
- Weight Loss Program
- Gluten Restricted
- Low-fat

Have you ever had a nutrition consultation? Yes No

Do you AVOID any particular food? Yes No

If you could only eat a few foods each week, what would they be (*three favourite foods)?

Do you grocery shop? Yes No **If no,** who does the shopping?

Do you read food labels? Yes No **If yes,** what do you look for?

Do you cook? Yes No **If no,** who does the prep/cooking?

How many meals do you eat out per week? 0–1 2–3 4–5 >5

Do you consume soda pop, fruit juice or trendy beverages sweetened with sugar or fruit juice?

Yes No **If yes:** 1–2x per week 3–4x per week ≥5 per week

FOOD JOURNAL (typical daily food choices/preferences)

Morning

Lunch

Dinner

Snacks

Beverages

Check all factors that apply to your current lifestyle and eating habits:

- Binge eater
- Late night eating
- Emotional eater
- Eat 50% of meals away
- Don't like cooking
- Lack access to healthy food
- Don't plan meals/recipes
- Make fast food choices
- Confused about nutrition advice

One food habit or lifestyle choice that you know **does not** support your health, **that you would like to change**:

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Do you currently **smoke** (tobacco, marijuana, vape)?: Yes No

If so, how often?: Quantity:

Do you consume **alcohol**? Yes No

If so, how often?: What Type?

Do you consume **other substances**? Coffee Caffeinated Sodas Red Bull

EXERCISE

Current Exercise Program

Specify type, sessions/week, and duration:

- Stretching (yoga or pilates)
- Cardio (walking, hiking, cycling, swimming)
- Strength (weight training, circuit)
- Leisure Activities or Sports (tennis, golf, skiing, hockey)

PSYCHOSOCIAL

How well have things been going for you? (Rate on a scale of 1–10, with 10 being great!)

Overall Partner Friends Family Work Community

What would you like **more** of in your life?

What would you like **less** of in your life?

What resources do you have for **emotional support**? (Check all that apply):

Spouse Family/Friends Pets Spiritual/Counselling Nature

Other:

How well do you **sleep** overall? (On a scale of 1–10, with 10 being great!):

Hours per night:

ENVIRONMENTAL & DETOXIFICATION ASSESSMENT

Do you have any known **food** related intolerances, sensitivities, allergies* or serious adverse reactions?
(*food allergies indicate a serious reaction you may have to food items)

Yes No **If yes,** list all:

Do you have any **adverse reactions** to (check all that apply):

Caffeine Alcohol Preservatives MSG Cow's Milk Gluten Garlic

Citrus Chocolate Cigarette Smoke Perfumes Auto exhaust

Sulfite-containing foods (wine, dried fruit, condiments) Other:

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In your workplace or home, have you ever been exposed to or are currently exposed to:

☐ Industrial Chemicals ☐ Electromagnetic Radiation ☐ Mold ☐ Other:

Do you have a known history of significant exposure to any harmful chemicals such as:

☐ Herbicides ☐ Pesticides ☐ Insecticides ☐ Organic Solvents ☐ Heavy Metals

☐ Other:

Do you dry clean your clothes? ☐ Yes ☐ No

Do you have any pets? ☐ Yes ☐ No **If yes** please describe:

READINESS ASSESSMENT

In order to improve your health, how willing are you to engage in the following:
(Rate on a scale of 1–5, with **1 = not willing, 5 = very willing**)

5 Modify your diet and habits?

5 Purge your pantry, grocery shop, and provide staples?

5 Plan meals, prep food or use a food prep service?

5 Modify your lifestyle to reduce stress (new habits)?

5 Engage in regular movement (walking and.or stretching)?

Rate the following questions on a scale of 1–5, with **1 = not willing, 5 = very willing:**

How confident are you in your ability to organize and follow through on simple wellness activities? 5

If you are not confident of your ability, what aspects of yourself or your life are holding you back?

At the present time, how supportive do you think the people in your life will be to you implementing changes? 5

How much ongoing support and contact (phone, virtual platform, or email) would help you implement your personal health program?

☐ Weekly ☐ Monthly ☐ Every 3 months

SYMPTOMS QUESTIONNAIRE

Please check if the symptom **applies to you.**

Energy Levels & Temperature

☐ Fatigue, sluggishness

☐ Lack of stamina or strength

☐ Apathy, lethargy and weakness

☐ Hyperactivity

☐ Restlessness

☐ Feel cold, regularly (whole body)

☐ Feel hot, or excessive perspiration

☐ Significant energy highs & lows (*erratic blood sugar)

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Appetite & Thirst

- [ ] Ravishingly hungry all the time
- [ ] Normal or need to eat regularly
- [ ] Poor appetite in the morning
- [ ] Dry mouth or constant thirst
- [ ] Prefer cold drinks & gulp
- [ ] Prefer warm drinks & sip
- [ ] Absence thirst
- [ ] Forget to hydrate

Digestion

- [ ] Nausea or vomiting
- [ ] Acid reflex, heartburn, or GERD
- [ ] Irritable Bowel Syndrome (IBS)
- [ ] Feel excessive fullness after meals
- [ ] Bloating or fluid retention
- [ ] Gas or flatulence
- [ ] Hiccups or belching
- [ ] Diarrhea after meals

Stools

- [ ] Loose or soft stools
- [ ] Mucous or undigested food in stools
- [ ] Intestinal cramping or pain
- [ ] Constipation and/or laxative use
- [ ] Blood in stools
- [ ] Itchy anus or genitals

Urination

- [ ] Frequent or excessive
- [ ] Urgent urination, unable to hold
- [ ] Wake up to urinate
- [ ] Itchy genitals and/or white discharge
- [ ] Dark yellow colour or strong odour
- [ ] Blood in urine
- [ ] Frequent bladder infections
- [ ] History of kidney stones

Sleep

- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Chronic insomnia
- [ ] Slow to rise in the morning
- [ ] Sound or restful sleep
- [ ] Dream disturbed or nightmares
- [ ] Night sweats or dry mouth at night
- [ ] Snore or have sleep apnea

Reproductive Health — Women

Menstrual Cycle ◯ Regular ◯ Irregular ◯ Absent

Menstrual Discomfort ☐ Cramps ☐ Bloating ☐ Headaches ☐ Mood changes

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Reproductive Health — Women continued

Menopausal Status ◯ Perimenopausal ◯ Postmenopausal

Menopausal Symptoms ☐ Insomnia ☐ Weight gain ☐ Depression ☐ Hot flashes ☐ Fatigue

Reproductive Health — Men

☐ Decreased libido ☐ Frequent urination ☐ Inflammation of Prostate

Abnormal Hormone Levels: ☐ DHEA ☐ Testosterone ☐ Estrogen ☐ Cortisol

Andropause Symptoms ☐ Hair loss ☐ Fatigue ☐ Insomnia ☐ Weight gain

Discomfort or Pain

☐ Heart palpitations, pounding or rapid heartbeat ☐ Chest pain or tightness

☐ Slow or irregular heartbeat ☐ Poor circulation

☐ Stiffness or difficulty walking ☐ Backache or knee pain

☐ Numbness or tingling in hands or feet ☐ Pain or strain in muscles

☐ Joint pain or dry cracking joints ☐ Varicose veins

Swelling or Fluid Retention: ☐ Feet/Ankle ☐ Behind the Knee ☐ Groin/Inner Thigh ☐ Pelvis

☐ Abdomen ☐ Chest/Underarms ☐ Wrist/Hands

Skin

☐ Hives or rashes ☐ Dry Flaky Skin

☐ Acne or blemishes ☐ Eczema or Psoriasis

☐ Skin tags, dark lumps or changing moles ☐ Bruise easily

Head, Eyes & Ears

☐ Headaches ☐ Migraines Location on head:

☐ Faintness or dizziness When does it occur?

☐ High Blood Pressure ☐ Low Blood Pressure BP Score

☐ Dry Eyes ☐ Red or itchy eyes When does this occur?

☐ Dark circles or puffy bags under eyes ☐ Spots or floaters in field of vision

☐ Poor Night Vision or blurry vision ☐ Ringing in the ears or tinnitus

☐ Hearing loss ☐ Ear infections How often?

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Mouth, Teeth & Bones

- [ ] Canker sores or ulcers
- [ ] Bad breath
- [ ] Bitter taste in mouth
- [ ] Grind teeth
- [ ] Neck or jaw tension
- [ ] Bleeding gums
- [ ] Mercury fillings and/or root canals
- [ ] Tooth decay and/or fractures
- [ ] Hoarseness or dry mouth
- [ ] Swollen/discoloured tongue or gums

Lungs & Throat

- [ ] Chronic congestion, runny nose
- [ ] Phlegm, need to clear throat often
- [ ] Frequent illness, colds or flu
- [ ] Nose bleeds

Recurring respiratory issues, please specify:

- [ ] Asthma
- [ ] Bronchitis
- [ ] Sinus infections
- [ ] Hay fever
- [ ] Difficulty breathing, winded easily and/or wheezing

Emotions & Mind

- [ ] Anxiety, fear or nervousness
- [ ] Anger, irritability or aggressiveness
- [ ] Depression
- [ ] Poor memory
- [ ] Confusion or poor comprehension
- [ ] Difficulty concentrating
- [ ] Difficulty making decisions
- [ ] Slurred speech or stuttering
- [ ] Highly reactive and stressed (tired & wired)

Body Composition

- [ ] Height
- [ ] Weight
- [ ] Waist/Hip Ratio

Waist/Hip Ratio = $\frac{\textbf{Waist measurement} \text{ (in inches)}}{\textbf{Hip measurement} \text{ (in inches)}}$

***Healthy Range:** Men **<0.8** Women **<0.9**

- [ ] Weight fluctuation (>10 lbs)
- [ ] Water retention or bloating
- [ ] Fatty Liver
- [ ] Binge eating or drinking
- [ ] Overweight or underweight
- [ ] Compulsive eating or starvation

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CLIENT INFORMATION & CONSENT FORM

Dynamic by Nature offers educational and therapeutic sessions designed to develop strategies for personal wellbeing. These include nutrition and lifestyle support; personal fitness training; and self-reflection practices.

Consultations with Judy Chambers/Dynamic by Nature Ltd. do not include diagnosis or medical advice, and are intended to complement your doctor's treatment. Your physician can and should be advised of any information or recommendations discussed in these sessions.

Dynamic by Nature advises that each client continue to seek the medical care of a licensed physician, if they are currently under the care of a licensed physician.

Statement of Consent

I hereby attest that I am here today and at any subsequent consultation/session, solely on my own personal behalf (and/or on behalf of my immediate family) to receive personal training and/or learn nutritional and lifestyle information, that I may choose to apply in my everyday life. I recognize that the services offered by Judy Chambers/Dynamic by Nature Ltd. do not involve medical diagnosis or treatment of any disease. I undertake full responsibility for my own wellbeing as it relates to these sessions.

Cancellation Policy

In signing this form, I also understand and accept that a fee of $100.00 (partial appointment fee) will be charged to my account, if my cancellation or rescheduling is not done 24 hours prior to the date of my appointment, and Judy Chambers/Dynamic by Nature Ltd. is unable to fill that space.

Print/type Client Name in Full

Print/type Name of Representative, if represented by another

Client Signature

Signature of Representative, if represented by another

Date

SAVE CLEAR PRINT SUBMIT

Please complete and return prior to your appointment