Paris Holistic Health

** Nutrition Client Information Form**

(Please Print)

Name: Birthdate:

Address:

Home Phone: Cell: Work Phone:

Email:

Add me to your mailing list (circle one): Yes No

Emergency Contact:

How did you hear about us?

Are you currently under the care of a physician?

If Yes, Physician’s Name:

**Medications & Supplements**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medications (Over-the-Counter and Prescription)** | | | | | |
| Name | | Dosage | Frequency | Length of Time | Reason for Taking |
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| Are you sensitive to low levels of medication(s) and/or caffeine (circle one)? | | | Y N | | |
| **Vitamins, Minerals or Herbal Supplements** | | | | | |
| Name | Brand | Dosage | Frequency | Length of Time | Reason for Taking |
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Have you seen a Nutritionist before?

If yes, when was your last session?

Do you have a particular area of concern?

Any nutritional issues in childhood?

Any nutritional issues as an adult?

Any known allergies (food, medication, chemicals and/or environmental)?

List the type of reaction experienced and severity (mild, moderate, severe, life-threatening)?

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| --- | --- | --- | --- | --- | --- | --- |
| **Diet** | | | | | | |
| Food/Drink | Frequency | | | | | Comments |
|  | Never or Rarely (< 1x/Month) | Occasionally  (< 1x/Week) | Regularly  (> 1x/Week) | | Most Days  of the Week |  |
| Caffeine |  |  |  | |  | In what form? |
| Soda/Soft Drinks |  |  |  | |  | What type(s)? |
| Alcohol |  |  |  | |  | What type(s)? |
| Red Meat |  |  |  | |  | Beef,  Lamb |
| White Meat |  |  |  | |  | Poultry,  Pork |
| Eggs |  |  |  | |  |  |
| Fish |  |  |  | |  |  |
| Nuts & Seeds |  |  |  | |  |  |
| Fruits |  |  |  | |  | Canned,  Fresh,  Frozen |
| Vegetables |  |  |  | |  | Canned,  Fresh,  Frozen |
| Plant Oils (e.g., olive) |  |  |  | |  | What type(s)? |
| Dairy Products |  |  |  | |  | Milk,  Yogurt,  Cheese,  Butter |
| Soy Products |  |  |  | |  |  |
| Bread & Other Grains |  |  |  | |  | What type(s)? |
| ”Junk / Fast Food” |  |  |  | |  | What type(s)? |
| Fried Foods |  |  |  | |  | What type(s)? |
| How many times each week do you eat each meal at home (vs. out)? | | | | Breakfast,       Lunch,       Dinner | | |
| How many ounces of water do you drink per day? | | | | oz  Bottled,  Filtered,  Tap | | |

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| --- | --- | --- | --- | --- | --- |
| **Lifestyle** | | | | | |
|  | Frequency | | | | Comments |
|  | Never or Rarely (< 1x/Month) | Occasionally  (< 1x/Week) | Regularly  (> 1x/Week) | Most Days  of the Week |  |
| Exercise |  |  |  |  | What type(s)? |
| Socializing w/Friends |  |  |  |  |  |
| Relaxation |  |  |  |  | What type(s)? |
| Self-Pampering |  |  |  |  | What type(s)? |
| Tobacco |  |  |  |  | What type(s)? |
| Recreational Drugs |  |  |  |  | What type(s)? |

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| **Sleep** | |
| At what time are you typically in bed? |  |
| What time do you fall asleep? |  |
| Typical hours asleep? |  |
| # of times you awaken during the night |  |
| Reason(s) why you wake during the night |  |
| Do you wake to an alarm clock? |  |
| Do you feel rested upon rising? |  |

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| **Stress** | | | | | | | | | | | | | | |
| On a scale of 1-10, with 1 being low and 10 being high, how stressful is your: | | | | | | | | | | | | | | |
| Work: |  | | Social/family situation: | |  | | | Current health status: | | |  | Life in general: | |  |
| Do you feel that your current state of health is: | | | | | largely in your control or  largely out of your control | | | | | | | | | |
| What do you believe you can do to make a difference in your current health status? | | | | | | | | |  | | | | | |
| If so, what 1-2 key steps have you already taken? | | | | | |  | | | | | | | | |
| **Moods You Experience Frequently** | | | | | | | | | | | | | | |
| accepting | | | | anxious or nervous | | | angry | | | capable | | | compassionate | |
| determined | | | | dreadful | | | empowered | | | enthusiastic | | | fortunate | |
| guilty | | | | happy | | | hopeful | | | hurt | | | inspired | |
| lonely | | | | loved | | | peaceful | | | resentful | | | resigned | |
| sad | | | | scared | | | terrified | | | tired | | | uncertain | |
| other: | | | | | | | | | | | | | | |
| **Significant Life Events** | | | | | | | | | | | | | | |
| Please list major events in the last ten years of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, illness, and anything else you feel greatly impacted your life. | | | | | | | | | | | | | | |
| Date | | Event | | | | | | | | | | | | |
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Client Signature: Date:

(Parent/Guardian Signature if under 18 years old)

**Privacy Notice:**

No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.