Heidi Seidman
REGISTERED HOLISTIC NUTRITIONIST

CLIENT INTAKE FORM

Consultations with Heidi Seidman 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.

Please continue to seek the medical care of a licensed physician.
ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Name (last): _____ (first): _____
Address: _____ City: _____
Province: _____ Postal Code: _____
Phone: (H):_____ (W): _____
E-mail: _____ Fax: _____
Sex (M/F): ____ Height: _____ Weight: _____
Date of Birth: D/ M/ Y _____ Blood type (if known): _____
Place of Birth: _____ Occupation: _____
Physician's Name: _____ Phone: _____
Emergency Contact: _____ Phone: _____

ASSESSMENT HISTORY

PART I: HEALTH

1. What are your present complaints/concerns? Describe onset of condition; what makes it worse/better?

2. Please list any major past illness, surgery, accident or toxin exposure, and your age at the time.

3. Describe (with date) any major past drug use, including marijuana, antibiotics, alcohol, birth control.

4. Are you currently taking any prescription medication, herbal remedies and/or nutritional supplements? If so, please list and categorize them.

5. Have you had recent surgery?

6. Are you or could you be currently pregnant?

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7. Please indicate "X" for self, "F" for Father, "M" for mother, "S" for siblings, "G" for grandparents.

☐ Heart disease	☐ Arthritis	☐ Mental illness
☐ Suicidal	☐ High blood pressure/Cholesterol	☐ Depression
☐ Cancer (indicate type):	☐ Parkinson's or Alzheimer's	☐ Alcoholism
☐ Diabetes	☐ Other:	

8. Do you often/currently experience any of the following (mark 'X' for those that apply):

☐ Feel cold	☐ feel warm/hot	☐ cold hands/feet	☐ hot palms/soles
☐ hot flashes	☐ night sweating	☐ afternoon sweating	☐ chills/fever

9. Do you have enough energy on a regular basis? Describe any 'ups and lows', including time of day.

10. Please describe your appetite: ☐ strong ☐ moderate ☐ low ☐ irregular

11. Do you have cravings (C) or dislikes (D) for foods/drinks that are:
☐ sweet ☐ salty ☐ spicy ☐ sour ☐ fatty/rich ☐ bitter ☐ crunchy ☐ ice cold

12. How is your digestion? Please describe any discomfort, gas, bloating you may experience.

13. Please describe your thirst, and any preference for warm or cold drinks.

14. How often do you urinate?

15. Is your Urine? ☐ Dark yellow ☐ Medium yellow ☐ Clear ☐ Blood ☐ Odor

16. How frequently do you have a bowel movement?

17. Do you experience any of the following (mark 'X' for those that apply)?

☐ Loose/diarrhea	☐ Strong odor	☐ Mucous in stools
☐ Constipation/strain	☐ Blood in stools	☐ Undigested food particles (describe):

18. Do you experience any strong emotions on a regular basis (mark 'X' for those that apply)?

☐ Grief/Sadness	☐ Depression	☐ Joylessness	☐ Fear/Insecurity
☐ Excitement	☐ Confusion	☐ Perfectionism	☐ Forgetfulness
☐ Anger	☐ Lack of focus	☐ Intense dreaming	

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19. Do you have any skin conditions? Please describe.

20. Please indicate if any of these apply to you (mark 'X' for those that apply):

☐ Abnormal bleeding	☐ Abnormal bleeding	☐ Root canals	☐ Bruise easily
☐ Mercury (silver) fillings	☐ Nails break easily	☐ Joints crack often	☐ Grind teeth
☐ Dry / red /itchy eyes	☐ Ringing in ears	☐ Low sex drive / other sexual difficulties	☐ Hysterectomy / Vasectomy
☐ Difficulty falling asleep	☐ Wake up during the night	☐ Groggy in morning	

21. WOMEN: Please describe your menstruation and reproductive history (mark 'X' for those that apply):

# of pregnancies ___	# of adoptions ___	# of miscarriages ___	# of abortions ___
☐ Light flow	☐ Heavy flow	☐ Regular	☐ PMS
☐ Cramps	☐ Irregular	☐ Pale blood	☐ Dark blood
☐ Clots	☐ Tender breasts	☐ Breastfeeding	☐ Mood changes
☐ Post Menopause			

22. Have you lived in / traveled to tropical countries (describe)?

23. Do you have a preference or dislike for certain times of day, seasons or types of weather?

PART II: DIET & LIFESTYLE

24. Please describe your average daily diet in detail, including mealtimes, preferred foods, and amounts.
Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

25. Do you follow a specific dietary (Vegan, vegetarian, gluten free etc)

26. Do you have any allergies or food sensitivities and if so, please describe?

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27. On a scale of 1 to 4, please describe your habits: 1 (never), 2 (rarely), 3 (sometimes) or 4 (often)

- Organic fruits and vegetables ___
- Conventional (non-organic) fruits and vegetables ___
- Coffee ___
- Alcohol ___
- Sugary foods (candy, fruit juice, baked goods) ___
- White flour products (pasta, bread, baked goods) ___
- Processed and/or non-organic meats ___
- Farmed Fish ___
- Organic, free-range meats ___
- Wild fish ___
- Margarine ___
- Artificial sweeteners ___
- Whole grains (quinoa, spelt, amaranth, whole wheat, kamut) ___
- Cold-pressed, organic oils (olive, hemp, flax, coconut) ___
- Deep-fried foods ___
- Eat after 8 pm ___
- Cigarettes ___
- Marijuana ___
- Processed foods ___
- Microwave ___

28. List the type of exercise you enjoy and frequency:

29. List the regular relaxation, hobbies, meditation, prayer and/or spiritual activity you do:

30. How many hours per day do you work/study? ___

31. Describe your nightly sleep pattern. IE Do you wake up during the night? Have trouble falling asleep?

32. How many hours daily do you: Drive ____ Take transit ____ Use computer ____Watch TV __

33. What level of stress are you currently experiencing? (1: none ... 10: unbearable) ___

34. What are the major factors influencing your stress?

35. Are there any dietary and/or lifestyle changes you would like to make?

36. Do you ever miss a meal? How do you feel if you do?

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37. Cravings? Please describe.

38. Favorite foods?

39. Most disliked foods?

40. Please list the three most important diet goals you wish to achieve:
1)

2)

3)

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CONSENT FORM

Nutritional Client Statement

I hereby attest to the following:

That I am here, on this and any subsequent visit, solely on my own behalf and not as an agent for any Federal, Provincial, Municipal and/or professional agency on a mission of entrapment or investigation.

I fully understand that Heidi Seidman, R.H.N. is not a medical doctor and I am not here for medical diagnostic or treatment procedures.

The services provided by Heidi Seidman, R.H.N. are at all times restricted to consultation on the subject of nutritional health matters intended for general wellbeing and do not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of any disease, or any licensed or controlled act which may constitute the practice of medicine in this province.

This agreement is being signed voluntarily and not under duress of any kind.

Full Name (PLEASE PRINT):_____

Address:_____

Telephone:_____

Email:_____

Signature:_____

Date:_____