julia denker
holistic nutritionist

client intake form

the following form provides an overall assessment of your current health status.

these questions will help to identify underlying causes of nutritional imbalances & assist me in formulating an effective nutrition plan specific to your goals/concerns.

please respond as thoughtfully & accurately as possible.

personal information

first name: _____

last name: _____

address: _____

_____

city: _____

postal code: _____

home #: _____

work #: _____

cell #: _____

email: _____

date of birth: _____ / _____ / _____
month *day* *year*

occupation: _____

hrs on a computer (daily): _____

marital status: _____

number of children: _____

number/type of pets: _____

height: _____ ft _____in

weight: _____lbs

average sleep: _____ hours/day

time: _____ am/pm

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current health status & goals

please list your current concerns & goals & rank by priority.
fill in all boxes as completely as possible.

	mild/moderate/severe	treatment approach	success
ie: dry skin	*moderate*	*elimination diet*	*moderate*
concerns			
goals			

describe the development of your health concerns. for example: when did this problem first appear? did it ever go away & then return? what was happening in your life when this condition first appeared?

concerns

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medical & surgical history

please list all medical conditions, accidents, & surgical procedures you have undergone.

surgery	date	comments
ie: appendix removed	*september 1995*	*7 amalgams done*

dental history

please list all dental procedures you have undergone.

surgery	date	comments
ie: dental amalgams	*september 1985*	*7 amalgams done*

family history

please indicate any current or historic family conditions or illnesses.
include maternal & paternal grandparents if possible.

	illnesses
father	
mother	
sibling	
sibling	
maternal grandfather	
maternal grandmother	
paternal grandfather	
paternal grandmother	

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medicinal history

please indicate if you use any of the following medications:

	never/rarely *(approx. 1x per /year)*	sometimes *(less than 1x /month*	often (less than 1x /week)	regularly *(daily)*
antacids:	☐	☐	☐	☐
acid inhibitors: (ie. zantac, losec)	☐	☐	☐	☐
antibiotics:	☐	☐	☐	☐
oral antifungal:	☐	☐	☐	☐
anti-inflammatory: (ie. advil, aspirin, tylenol)	☐	☐	☐	☐
antihistamines: (ie. claritin)	☐	☐	☐	☐

other medications & vaccinations

medicine/vaccine name & reason	dosage/frequency	date started/finished

are you allergic to any medications? ☐ yes ☐ no
if yes, please list this medication & the nature of the reaction you have to it:

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supplement history

list all vitamins, minerals, & other nutritional supplements you are presently taking.

name of vitamin/mineral/herb/supplement	dosage/frequency	status/date started

dietary information

do you have any food cravings? ☐ yes ☐ no

if yes:

☐ sweet/sugary foods ☐ bread/pasta

☐ salty foods ☐ other: _____

are you on a special diet? ☐ yes ☐ no

if yes, please specify:

do you like to cook at home? ☐ yes ☐ no

if yes, how often? _____times/week

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please carefully list an *average* day's food consumption. try to be as detailed as possible, & include approximate quantities in the space provided.

meals

breakfast: (_____ am) _____

lunch: (_____am/pm) _____

dinner: (_____pm) _____

snack: (mid-morning) _____

snack: (mid-afternoon) _____

snack: (after dinner) _____

beverages

item: _____ qty: _____ time of day: _____

item: _____ qty: _____ time of day: _____

item: _____ qty: _____ time of day: _____

please indicate if you consume any of the following & the approximate number of servings per week.

	# of servings (weekly)	serving size (type/description)
luncheon meats		
candy		
margarine		
soft drinks		
coffee		
sweets/pastries		
fast foods		
fried foods		

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do you consume alcohol? ☐ yes ☐ no
if yes,
_____ drinks/times per week

have you ever used recreational drugs? ☐ yes ☐ no
if yes,
please list which drugs presently _____

please list which drugs in the past _____

have you ever used tobacco? ☐ yes ☐ no
if yes,
number of years as a smoker _____

amount smoked per day _____

year quit _____

have you been exposed to any other notable toxins? ☐ yes ☐ no
(ie. worked as painter, welder, disease mechanic, house had asbestos, black mold, live close to high tension power lines)
if yes, please describe: _____

_____

_____

_____

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digestive health

do you have any known food allergies? ☐ yes ☐ no
if yes, please list: _____

do you have any known environmental or chemical allergies? ☐ yes ☐ no
if yes, please list: _____

bowel movements

frequency:		consistency :	
more than 3 times a day	☐	soft & well formed	☐
2 to 3 times a day	☐	small & hard	☐
1 time a day	☐	loose but not watery	☐
3 to 5 times a week	☐	alternating between hard & loose/watery	☐
2 or fewer times a week	☐	pencil thin	☐
other	☐		

general colour of stool: _____

intestinal gas

daily	☐	present with pain	☐
occasionally	☐	foul smelling	☐
excessive	☐	little odor	☐

women`s health

regular periods? ☐ yes ☐ no duration of typical period _____

pms symptoms _____

menopausal symptoms _____

fertility issues _____

number of pregnancies _____ number of children _____

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urination			
frequency	odour	colour	other (ie. cloudy)

chemical exposure

please indicate the usage of any of the following items:

item/chemical	frequency	date started/current status
microwave		
aluminum cookware		
electric blanket		
antiperspirant		
cosmetics		
perfume		
hairspray		
pesticides (lawn/garden)		

lifestyle

please rank you level of satisfaction in the following areas of your life:

	excellent	fair	poor	very poor	n/a
school	☐	☐	☐	☐	☐
job	☐	☐	☐	☐	☐
social life	☐	☐	☐	☐	☐
close friends	☐	☐	☐	☐	☐
significant other	☐	☐	☐	☐	☐
children	☐	☐	☐	☐	☐
parents	☐	☐	☐	☐	☐

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stress

how would you rank your overall stress level? *low* 1 2 3 4 5 6 7 8 9 10 *high*
please list your sources of stress in order of priority:

_____

_____

how do you deal with your stress?

_____

_____

exercise

do you exercise regularly? ☐ yes ☐ no
if yes, how many times a week? ☐ 1x ☐ 2x ☐ 3x ☐ 4x or more

when you exercise, how long is each session? ☐ <15 min ☐ 16-30 min ☐ 31-45 min ☐ >45 min

what type(s) of exercise do you do?

☐ jogging ☐ walking ☐ hiking ☐ other: _____
☐ cycling ☐ snow sports ☐ water sports
☐ strength training ☐ aerobics ☐ martial arts

health goals

please rank the following:

importance of immediately improving your health: *low* 1 2 3 4 5 6 7 8 9 10 *high*
your current motivation to accomplish your goals: *low* 1 2 3 4 5 6 7 8 9 10 *high*
your openness to be coached to optimal health: *low* 1 2 3 4 5 6 7 8 9 10 *high*

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the challenge(s) I feel I have with making changes to improve my health include:

1 - _____

2 - _____

3 - _____

I am willing to address these challenges by:

1 - _____

2 - _____

3 - _____

client statement

i hereby attest to the following:

1. i fully understand that **julia denker** is not a medical doctor & i am not visiting her for medical diagnostic or treatment procedures.

2. the services provided by **julia denker** are at all times restricted to consultation on the subject of nutritional matters intended for general nutritional well-being & 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.

3. this agreement is being signed voluntarily & not under duress of any kind.

name: _____
(please print)

signature: _____

date: _____