urbanwellness
HOLISTIC HEALTHCARE

Kristin Tait, B. Kin, RHN, RNCP
Registered Holistic Nutritionist
Reiki Practitioner

Intake form

Welcome! Please complete this form to the best of your ability, as your answers will be a great asset in helping your practitioner to assist you with your health concerns and ultimately your return to optimal health and functioning. Please bring this form with you to your first appointment. If for ay reason you have any difficulty filling out this form your practitioner can go through it with you during your initial visit.

Name: ____________________________________ Date: __________________________

Date of birth: ______________________ Age: _____ Gender: male: ❒ Female: ❒

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ common-law ❒ Same sex

Live with: ❒ Alone ❒ Spouse ❒ Partner ❒ Children, (how many? _____) ❒ Roommate ❒ Parents

Contact Information

Address: ____

City: __________________________ Province: _______________________ Postal code: _______________

Phone: Home: _____________________ Business: ____________________ Mobile: ___________________

E-mail: ____

Emergency Contact

Name: _________________________________ Relation: ___________________________________

Phone: Home: _____________________ Business: ____________________ Cell: ____________________

Healthcare Providers

Primary Healthcare Physician: ____________________________ Phone: __________________________

When was your last physical exam? ____

Are you presently under the care of a specialist? ________________

Name: __________________________ Specialty: ____________________ Phone: _________________
Name: __________________________ Specialty: ____________________ Phone: _________________
Name: __________________________ Specialty: ____________________ Phone: _________________

Are you presently under the care of complementary/alternative health care providers?

Name: __________________________ Specialty: ____________________ Phone: _________________
Name: __________________________ Specialty: ____________________ Phone: _________________
Name: __________________________ Specialty: ____________________ Phone: _________________
Name: __________________________ Specialty: ____________________ Phone: _________________

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Health Concerns

What is your purpose in coming here today?

What are your main health concerns or complaints in order of greatest importance to you?

1. ____
2. ____
3. ____
4. ____
5. ____

When did your main health concerns or illness begin?

Did something trigger your change in health?

When was the last time you felt well?

What makes you feel worse?

What makes you feel better?

What do you think you need to heal?

Have you ever been diagnosed with an illness or ailment related to your health concern(s)?

Has there been an event or illness from which you have never fully recovered?

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Can you recall any traumatic events… surgeries, drug reactions, life traumas – deaths, or major life events that may have precipitated or aggravated your health concerns?

Have you experienced any trauma or loss in the past 5 years?

Do any events/moments in your life stand out as being most stressful?

If you could erase three problems in your life, what would they be?

1. ____
2. ____
3. ____

Do you or have you experienced any of the following?

❒ Prolonged sadness/	❒ Easily angered	❒ Mental illness	❒ Panic attacks
❒ Anxiety/ Nervousness	❒ Indecision	❒ Mood swings	❒ Memory
❒ Depression	❒ Irritability	❒ Phobia	

Lifestyle

How many hours on average do you sleep in a day (include naps)? ___________
What time do you go to sleep? ________________________ Awaken? ____________________________
Do you awaken feeling rested? __________

What is your fatigue/energy level on a scale of 1-10?

1 2 3 4 5 6 7 8 9 10
(low energy) (high energy)

At what time of the day is your energy highest? _________________________
At one time of your day is your energy lowest? ______________________

What is your occupation? ____
Do you enjoy your work? ____
How many hours do you work each day? _______________________
At what times do you begin and end work? Begin: ___________ End: ___________

Do you smoke? _________ If so how much for how long? ______________________
If not, did you ever? ____ If so, for how long? ________ When did you quit? ________
Does anyone in your home or workplace smoke? ____________________
Do you use recreational drugs? ❍ Yes ❍ No
If yes, how often and what type? ____
Have you ever been treated for a drug or alcohol dependency? If yes, for what?
____

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Do you wish to gain weight? _______ Lose weight? ____________ How much? _____________
What is… your weight? ___________ height? ____________ weight a year ago? ______________
Have you lost or gained more than 10 lbs in the past 6 months? ______________________________

On average, how many hours do you spend a day:

_____ driving ______ watching TV ______ on computer ______ reading
_____ eating ______ exercising ______ listening to music ______ relaxing
_____ sleeping ______ time spent outdoors ______ time spent inside

What are your interests/hobbies?

Do you vacation regularly? ________ When was your last vacation? _________________________

Do you actively participate in any spiritual discipline? Yes ______ No _______
(Church, religious group, meditation, etc…)

On a scale of 1-10 what level of stress do you feel you are experiencing at this time?

1 2 3 4 5 6 7 8 9 10
(Low Stress) (High Stress)

What are the major causes of stress in your life? (Check all that apply)

___ family ___ spiritual ___ personal
___ financial ___ marriage ___unfulfilled expectations
___ career ___ health ___ other: _______________________

Do you believe stress is currently reducing the quality of life? ❒Yes ❒No

How does your stress manifest itself?

Do you use any coping mechanisms; if so what are they and do they help to reduce your stress?

On a scale of 1-10 what is your overall level of health at this time?

1 2 3 4 5 6 7 8 9 10
(Poor health) (Excellent health)

What behaviours or lifestyle habits do you currently engage in that you believe support your health?

What behaviours or lifestyle habits do you currently engage in regularly that you believe are NOT supportive of optimal health?

What could stand in the way of your ability to make healthy lifestyle choices and achieve your health goals?

Who in your life will support you in making healthy lifestyle changes?

Do you currently exercise? ❒Yes ❒No
If so what types of exercise do you participate in, and do you enjoy them?
Use the following chart to answer this question.

Type of Exercise	Frequency (How often you participate in this exercise per week)	Time (For how long do you typically do this exercise?)	Enjoyment Rate this on a scale of 1-10

Rate your level of motivation for including exercise in your life? ❒Low ❒Medium ❒High

List any problems that limit your activity:

Do you feel unusually fatigued after exercise? ❒Yes ❒No
If yes, please describe:

Do you have any specific goals where exercise is concerned? If so, please describe them below.

Is there anything standing in the way of you achieving these goals? If so, please explain:

Medical History

Birth History: ❒Term ❒Premature ❒Breech ❒C-section ❒Vaginal birth
❒Time of day: _________ where were you born? __________________________

Pregnancy and/or birth complications:

❒Breast Fed: How long? _________ ❒Bottle-fed ❒Colic

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What was your childhood health on a scale of 1-10:

1 2 3 4 5 6 7 8 9 10
(Poor health) (Excellent health)

Describe your childhood health:

Received antibiotics in childhood: ❒No ❒Yes: How often:____________ For what?________________________

Have you ever:

Been diagnosed with an illness? Explain:

Been hospitalized?

Dental History

Silver Mercury Fillings #______
Composite Fillings # _______
Gold Fillings # ______

Root Canals: # ______
Dental Implants # _____

❒Dentures
❒Tooth Pain

❒Bleeding Gums
❒Gingivitis

❒Mouth ulcers/lesions
❒ Problems with Chewing

Do you floss regularly? ❒Yes ❒No

Supplements

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are taking and what you are taking them for in the charts below.

Supplement (include the brand)	Total daily dose	Reason for Use	Duration of Use

Prescription Medications

Current Medications	Total daily dose	Reason for Use	Duration of Use

Please list any medications used in the past 12 months, but have now discontinued.

Medications During the Past 12 Months	Total daily dose	Reason for Use	Duration of Use

Please state the approximate number of times you have been on antibiotics in the past 10 years: ____________

Adverse Reactions

Have you had any adverse reactions to drugs (over-the-counter or prescribed), vaccines, plants, natural therapies, or foods? Please state the drug, therapy and/or food and describe the reaction that you had to it below.

1. ____
2. ____
3. ____
4. ____
5. ____

Family History

Please indicate which of your relatives has experienced any of these health conditions, or if you yourself currently have any of the below listed conditions.

Health Concern	Family Relative	Health Concern	Family Relative
Heart Disease		Arthritis	
Hypertension		Alzheimers/Dementia	
Intestinal Disease		Liver Disease	
Kidney Dysfunction		Osteoporosis	
Call Bladder problems		Migraines	
Diabetes		Cancer	
Thyroid problems		Stroke	
Alcoholism		Infertility	
Asthma		Easy brusing/bleeding	
Allergies		Other:	

Females:

Age of menarche:______________ Menses frequency (cycle length in days): ______________
Length of menses (days of bleeding): ______________
Pain: ❒Yes ❒ No
Clotting: ❒ Yes ❒ No
Have you ever skipped your period? ________ For how long? ___________________
Use of hormonal contraception such as: ❒BCP ❒Patch ❒Nuva ring ❒IUD
When and for how long?
____

Could you be pregnant? ❒ Yes ❒ No
Are you trying to conceive? _________________
Number of: Pregnancies: _____ Abortions: _____ Miscarriages: ______ Live births: ______
Are you pre-menopausal or menopausal? ❒ Yes ❒ No
Are you experiencing any menopausal symptoms ❒ Yes ❒ No
If yes, please specify? ____
Have you had a bone density test? If yes, what was the result? _____________________

Nutrition

Have you ever had a nutrition consultation? ❒ Yes ❒ No
Have you made any changes in your eating habits because of your health? ❒ Yes ❒ No
Describe in terms of what worked and what didn't:

Do you currently follow a special diet or nutritional program?

❒ Low Fat ❒ Low Carb ❒ High Protein ❒ Low Sodium ❒ Diabetic ❒ No Dairy
❒ No Wheat ❒ No Gluten ❒ No Eggs ❒ Vegetarian ❒ Vegan ❒ Other: ______________

What are your favourite foods and when and how often do you eat them?

Favourite Food	Frequency	Time of day

Do you avoid certain foods? If so, what are they, and why do you avoid them?

Food you avoid	Why you avoid it

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

Do you read food labels? ❒ Yes ❒ No ______________________________________
Do you cook? ❒ Yes ❒ No
If no, who does the cooking? ______________________________________
How many meals do you eat out per week? _________________
What the most important thing you think you should change about your diet to improve your health?
____
____
How many meals do you eat per day day? ______ At what times of day? ______________________________________
How many snacks do you eat per day? _______At what times of day? _____________________________________
Do you eat meals: ❒ With family ❒ Alone ❒ On the run
❒ At a restaurant ❒ fast food ❒ in front of the TV/engaged in other activities

Do you feel that there are restrictions to your diet due to others preferences – roommates, family, otherwise?
If yes, please explain:

Do you eat or use (indicate "1" for rarely, "2" for regularly and "3" for often):

_____ aluminum pans
_____ microwave
_____ Luncheon/smoked meats
_____ Artificial sweeteners (sucralose, splenda etc.)
______ Margarine
______ Fried foods
______ Fast foods
_______ Candy
_______ Refined foods

Please indicate how many cups of the following you consume per day:

______ bottled or spring water
______ fresh fruit juices
______ fruit juices (prepared)
______ Fresh vegetable juices
______ Soft drinks (regular)
______ Soft drinks (diet)
______ Tap water
______ Beer
______ Red wine
______ White wine
______ Other alcoholic
______ Coffee
_______ Milk (1% or 2%)
_______ Milk (skim)
_______ Black Tea
_______ Green Tea
_______ Herbal Tea

Other: (specify) ____

How many ½ cup servings do you eat of each in a day?
_______ Fruit: Fresh ______ Dried ________ Canned _______
_______ Vegetables: Cooked _______ Raw ________
_______ Whole grains
_______ Protein: Type ____
_______ Dairy: Type ____
_______ Other: Specify: ____

Give examples of your typical meals:

Breakfast: ____
____

Lunch: ____
____

Dinner: ____
____

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Snacks: ____
____

If you are a meat eater how often do you eat meat?
❒ Multiple times per day ❒ Daily ❒ 3-5x/week ❒ once/week or less

How often do you consume dairy products?
❒ Daily ❒ 3-5x/week ❒ once/week or less

Do you consume organic foods?
❒ Daily ❒ 5-7x/week ❒ 3-5x/week ❒ 1-3x/week ❒ Never

Do you experience any symptoms if meals are missed? Explain:

Do you experience any symptoms after meals? Explain:

Do you have known adverse food reactions or sensitivities? ❒ Yes ❒ No
If yes, to which foods and what is the reaction?

Food	Reaction

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

❍ Fast eater
❍ Erratic eating pattern
❍ Eat too much
❍ Late night eating
❍ Dislike healthy food
❍ Time constraints
❍ Eat more than 50% meals away from home
❍ Travel frequently
❍ Non-availability of healthy foods
❍ Do not plan meals or menus
❍ Reliance on convenience items
❍ Poor snack choices
❍ Significant other or family members don't like healthy
❍ Significant other or family members have special dietary needs or food preferences
❍ Love to eat
❍ Eat because I have to
❍ Have a negative relationship to food
❍ Struggle with eating issues
❍ Emotional eater (eat when sad, lonely depressed, bored)
❍ Eat too much under stress
❍ Eat too little under stress
❍ Don't care to cook
❍ Eating in the middle of the night
❍ Confused about nutrition advice

Do you have any environmental allergies (i.e. grass, mold, pets, pollen etc..)

Do you have an adverse reaction to caffeine? ❒ Yes ❒ No

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When you drink caffeine do you feel: ❐Irritable or wired ❐Aches & Pains

How often do you have a bowel movement? ______________________________________
Do you strain to have a bowel movement? ❍Yes ❍ No ❍ Occasionally
Is this related to a particular food or circumstances? ____
Do you have loose bowel movements? ❍ Yes ❍ No ❍ Occasionally
Is this related to a particular food or circumstances? ____

Bowel movement chart: please check according to your experience:

Frequency		**Consistency**		**Color**	
More than 3 per day		Soft and well formed		Medium brown consistently	
1-3 per day		Often float		Very dark or black	
4-6 per week		Difficult to pass		Greenish color	
2-3 per week		Diarrhea		Blood is visible	
1 or fewer per week		Thin, long and narrow		Varies a lot	
		Small and hard		Dark brown consistently	
		Loose but not watery		Yellow, light brown	
		Alternating between hard and loose/watery		Greasy, shiny appearance	

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Food Journal: *Please complete for three days prior to your initial visit.*

	Time	Everything I ate… including approximate amounts	I feel… energy/emotion/mental alertness
Pre-breakfast			
Breakfast			
Snack (mid-morning)			
Lunch			
Snack (mid-afternoon)			
Dinner			
Snack (evening)			
Medications / Supplements / Herbs / Other			

Food & Drink:

What did you notice (physically, mentally) after eating any of the above foods?

Water Intake: ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ cups (250 mL in one cup)

Digestion: Number of Bowel Movements: _____ Description (size, colour, undigested food, etc.):
____

Other observations (gas/bloating, burping, acid stomach, etc.):
____
____

Cravings for: salty sweet spicy chocolate coffee starches (breads, donuts, etc.)

Energy Level: (low energy) 1 2 3 4 5 6 7 8 9 10 (high energy)

Stress Level: (low stress) 1 2 3 4 5 6 7 8 9 10 (high stress)

Mood(s) & Emotions: How would you describe your mood(s) today? ________________________
Was there a time when your mood changed today? What happened? ____________
____

Exercise (#min./type): ____

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Lunch			
Snack (mid-afternoon)			
Dinner			
Snack (evening)			
Medications / Supplements / Herbs / Other			

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____
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____

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____

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____
____

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Mood(s) & Emotions: How would you describe your mood(s) today? ______________________
Was there a time when your mood changed today? What happened? ______________
____

Exercise (#min./type): ____

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Privacy Policy Consent Form

Kristin Tait

Consent Declaration

My office/business understands the importance of protecting your personal information. To help you understand how I am doing that, I have outlined below how the office is using and disclosing your information.

This office will collect, use and disclose only necessary information about you for the following purposes:

- To collect information for nutritional/physical based assessment
- To collect fees relating to the services offered by Kristin Tait
- To provide a means of communication between, Kristin Tait and the client/organization (via email or Canada Post mail) regarding services being offered at that time
- To provide information on seminars and workshops offered by Kristin Tait via: email or Canada Post (mail)
- To provide handouts and additional nutrition and wellness information via: email or Canada Post (mail)

DISCLOSURE:

- To the client's doctor/health practitioner(s)
- To colleagues of Kristin Tait, for the purposes of client nutritional and wellness support (all client confidentiality is maintained)

I will only share your information with your consent. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols.

I am trained in the appropriate uses and protection of your information.

The privacy officer of this office is Kristin Tait. If you have any questions regarding the Privacy Policy, please do not hesitate to ask.

Client Acceptance

I agree to this office collecting, using and disclosing personal information about me as set out above and in the Privacy Policy.

DATE: ____

PRINTED NAME: ____

SIGNATURE: ____

WITNESS: ____

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Nutrition Consultation: Client Statement

for the exclusive use of Kristin Tait, Registered Holistic Nutritionist

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I hereby attest to the following:

1. I fully understand that Kristin Tait, RHN, is not a medical doctor, and I am not here for medical diagnostic or treatment procedures. If I have any health problem, health condition, or disease, I am now being advised not to postpone or delay getting competent medical advice from a licensed doctor of medicine. I understand and agree that any service rendered by an RHN is not designed to cure or prevent any disease, pain, deformity, injury, or mental or physical condition of any kind. I am here to learn how to do this for myself.
2. The services performed by Kristin Tait, RHN, is at all times restricted to consultation on the subject of nutrition intended for building wellness and does not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of disease, or for any act for which a medical license is required.
3. This statement is being signed voluntarily and not under duress of any kind.
4. I am here on this, and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial, or municipal agency on a mission of entrapment or investigation.

Name (please print): ____________________

Date: ____________________

Signature: ____________________

Address: ____________________

City, Province: ____________________

Postal Code: ____________________

Phone (home): ____________________

Phone (work): ____________________

Email: ____________________

Birth date: ____________________

Referred by: ____________________

In case of emergency, contact
(name, phone #): ____________________