Simply Abundant Health

Client In-Take/ Registration Form

Patient Information:

Patient Name (First & Last):_____

Date of birth:_____/_____/_____Age:_____Sex:_____Marital Status: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Best Phone Number:_____Cell Phone (if different): _____

Email Address: _____

Who referred you today? _____

CONFIDENTIALITY:

Nutrition consulting/education is a confidential process designed to help you address your health concerns, come to a greater understanding of yourself and the relationship that diet and lifestyle practices can have one one's health,and learn effective dietary, lifestyle, supplemental and stress management strategies. All information gathered from the client, including name, contact information and medical history are secured and confidential. Any views expressed by the client to Sarah Kostusiak will be held with the utmost confidentiality. Information will only be released with the consent of the client unless said information may potentially be injurious to a third party.

Signature_____Date_____
(client/ parent/ guardian)

CONSENT:

I, the client, have read and understand the information about the holistic health services offered by Sarah Kostusiak. I have discussed with her the nature of the services to be provided. I understand that Sarah Kostusiak is not a licensed physician and as such cannot diagnose, treat or prescribe medications. I understand that the information provided on the relationship between nutrition and health is NOT meant to replace competent medical care or treatment for any health problem or condition and that it is my responsibility to maintain a relationship for myself/ child with a medical doctor or licensed health care practitioner. The nature of the nutrition assessment and evaluation are to support client wellness through food, herbs, nutritional supplements, education, exercise programs, and lifestyle changes. I certify that I am here solely on my own behalf. I am not representing any other person, company, association, and/or on the behalf of any governmental agency. I, the client, give consent to the nutrition assessment and evaluation.

Signature_____Date_____
(client/ parent/ guardian)

Financial Responsibility:

Initials

_____I understand that I am financially responsible for all services rendered to me and that no insurance is accepted.
_____I understand that if I cancel an appointment with less than 24 hours notice or fail to show up for an appointment I will be charged a fee of $25.

_____Date:_____
Signature of Client, Parent, Guardian, or Personal Representative

Simply Abundant Health

Confidential Health History

Client Name:_____Today's Date: _____
Age:_____Ht:_____Wt:_____Date of Birth:_____Date of last physical exam: _____
What is the primary reason for your visit? _____

SYMPTOMS Check all that you currently have or have had in the last year.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
__Chills	__Appetite poor	__Bleeding gums	__Breast lump
__Depression	__Bloating	__Blurred vision	__Erection difficulties
__Dizziness	__Bowel changes	__Crossed eyes	__Lump in testicles
__Fainting	__Constipation	__Difficulty swallowing	__Penis discharge
__Fever	__Diarrhea	__Double vision	__Sore on penis
__Forgetfulness	__Excessive hunger	__Earache	_____other
__Headache	__Excessive thirst	__Ear discharge	
__Loss of sleep	__Gas	__Hay fever	WOMEN ONLY
__Loss of weight	__Hemorrhoids	__Hoarseness	__Abnormal pap smear
__Nervousness	__Indigestion	__Loss of hearing	__Bleeding b/w periods
__Numbness	__Nausea	__Nosebleeds	__Breast lump
__Sweats	__Rectal bleeding	__Persistent cough	__Extreme menstrual pain
	__Stomach pain	__Ringing in ears	__Hot flashes
MUSCLE/ JOINT/ BONE	__Vomiting	__Sinus problems	__Nipple discharge
Pain, weakness, numbness		__Vision- Flashes	__Painful intercourse
in:	CARDIOVASCULAR		__Vaginal discharge
__arms _hips	__Chest pain	SKIN	_____other
__back _legs	__High blood pressure	__Bruise easily	Date of LMP_____
__feet _neck	__Irregular heart beat	__Hives	Date of last pap_____
__hands _shoulders	__Low blood pressure	__Itching	Have you had a
	__Poor circulation	__Change in moles	mammogram?_____
GENITO-URINARY	__Rapid heart beat	__Rash	Are you pregnant?_____
__blood in urine	__Swelling of ankles	__Scars	Number of children_____
__frequent urination	__Varicose veins	__Sore that won't heal	Number of pregnancies____
__lack of bladder control			
__painful urination			

CONDITIONS Check all that you currently have or have had in the past.

__AIDS	__Chemical dependency	__High cholesterol	__Prostate problem
__Alcoholism	__Chicken Pox	__HIV Positive	__Psychiatric care
__Anemia	__Diabetes	__Kidney disease	__Rheumatic fever
__Anorexia	__Emphysema	__Liver disease	__Scarlet fever
__Appendicitis	__Epilepsy	__Measles	__Stroke
__Arthritis	__Glaucoma	__Migraine headaches	__Suicide attempt
__Asthma	__Goiter	__Miscarriage	__Thyroid problems
__Bleeding disorders	__Gonorrhea	__Mononucleosis	__Tonsillitis
__Breast lump	__Gout	__Multiple Sclerosis	__Tuberculosis
__Bronchitis	__Heart disease	__Mumps	__Typhoid fever
__Bulimia	__Hepatitis	__Pacemaker	__Ulcers
__Cancer	__Hernia	__Pneumonia	__Vaginal infection
__Cataracts	__Herpes	__Polio	__Venereal disease

MEDICATIONS List medications AND Nutritional Supplements you are currently taking.

ALLERGIES To medications or substances.

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of health	Age at death	Cause of death	Check if your blood relative had any of the following:	
Father					__ADD/ADHD	__High blood pressure
Mother					__Allergies (airborne)	__Infertility
Brothers					__Allergies (food)	__Irritable bowel syndrome
					__Alzheimer's	__Kidney disease
					__Arthritis/ Gout	__M.S.
					__Asthma	__Meniere's
					__Bipolar	__Migraines
Sisters					__Cancer	__Parkinson's
					__Diabetes	__Seizures
					__Dizziness/ Vertigo	__Shingles
					__Hearing loss	__Speech disorder
					__Heart disease/ Stroke	__Thyroid disease

HOSPITALIZATIONS

YEAR	Reason for Hospitalization

PREGNANCY HISTORY

Year of birth	Sex of birth	Complications

HEALTH HABITS Check which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Alcohol	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS Check if your work exposes you to the following:

	Stress
	Hazardous substances
	Heavy lifting
	Other
What is your occupation?	

BLOOD TRANSFUSIONS Have you ever had a blood transfusion?_____ If yes, when?_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I also understand that completing this form is in no way holding Sarah Kostusiak liable for its review or actions upon any of the contents. I understand that this is provided to help jog my memory and offer as complete as possible a picture to my health coach so that we may consider as many factors as possible while I create my personal health goals.

_____Date_____

Signature of Client, Parent, Guardian, or Personal Representative

_____ Relationship to Client_____

Please print name of Client, Parent, Guardian, or Personal Representative

Simply Abundant Health

Diet & Lifestyle Questionnaire

Please know that there are NO right or wrong answers to any of these questions- this is just to give me a snapshot of where you are and how to best help you during our partnership.

Please list what kind/ brand you currently use for each of the following:

Deodorant/ Antiperspirant: _____

Toothpaste/ Floss/ Mouthwash: _____

Body wash/ Soap: _____

Face care/ anti-aging products: _____

Hair Cleaning Products: _____

Hair Grooming/ Styling Products: _____

Lotions/ Creams: _____

Perfume/ Cologne: _____

Make-up: _____

Bathroom/ Kitchen hand soaps: _____

Anti-bacterial/ waterless hand cleaners: _____

Home fragrance/ deodorizer/ candles/ oils etc: _____

Laundry soap/ softener/ additives: _____

Dishwashing detergent/ dish soap: _____

Do you have or have you had any silver dental fillings in your mouth? _____

What do you normally eat for:

Breakfast _____ Lunch _____

Dinner _____

Snack or desserts _____

What time do you stop eating at night? _____

What time do you eat breakfast? _____

How many times a day do you put food in your mouth? _____

Are there any foods you avoid? _____

Do you or any member of your family adhere to a specific diet such as Paleo, Vegan, Raw, Gluten- Free, Allergen free, Low Histamine or any other? _____

How many hours do you sleep each night? _____ Sleep Problems? _____

What do you do for exercise? _____

How do you deal with stress? _____

Client Name _____ Date _____