Burlington Natural Health Centre
1066 Brant Street, Burlington Ontario L7R 2J9
905-634-8598
Michael Colucci CNP., RNCP

Client Intake Form for Nutrition Counselling Services

Please complete the following form to provide us with the information we require for Nutrition Counselling Services.

Name: _____
Phone (H): _____
Phone (C): _____
Address: _____
Email Address: _____
Date of birth: _____
Age: _____
Occupation: _____
Parent or Guardian (If under 18 years):

Gender: _____
Weight: _____
Height: _____
Blood type: _____
Marital Status: _____
Emergency Contact: _____
Emergency contact #: _____
Referred by: _____
_____

Health Care Providers:

Medical Doctor: _____
Phone #: _____

Naturopathic Doctor: _____
Phone #: _____

Other Health Care Providers:

Provider: _____
Name: _____
Phone #: _____

Provider: _____
Name: _____
Phone #: _____

Health Concerns/goals (List in order of importance):

1. _____
2. _____
3. _____
4. _____

List paternal family conditions:

_____
_____
_____

List maternal family conditions:

_____
_____
_____

Do you have any pets? If yes, what kind?

_____
_____
_____

Do you exercise? Type and how often?

_____
_____
_____

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Section 1

How many bowel movements do you have per day? _____
What is the colour of your bowel movement? _____
Does your stool float? _____
Do you see any undigested food in your stool? _____
How do you feel after eating a heavy protein meal? _____
Do you have lots of gas? _____
Does it feel as if food "sits" in your stomach? _____
Does coffee help you have a bowel movement? _____
Ever have loose bowel movements? If yes, what is the trigger? _____
Please describe your bowel health in your own words:

_____
_____

Any changes in bowel health over the past month(s)/year? If yes, please describe.

_____
_____
_____

Do you have lots of energy throughout the day? _____

How do you feel after eating a meal? _____

Do you experience any lulls or highs in your energy level during the day?

_____

Section 2

Provide complete details about your entire health history. Be as specific and thorough as possible.

_____
_____
_____
_____

List any surgeries you've had done as well as any missing organs.

_____
_____
_____

List any dental work you have had done (example: silver amalgams, root canals, wisdom teeth)

_____
_____
_____

Females Only

At what age did your first menstrual cycle start? _____
How regular is your cycle? _____
Have you had any pregnancies? If yes, how many? _____
Have you used the birth control pill or any contraceptive? If yes, for how long? _____

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Section 3

List all supplements (vitamins, minerals, herbs, homeopathies, etc) you are taking and why you are taking them.

_____
_____
_____

List all prescription medication and non-prescription medications you are taking and why you are taking them.

_____
_____
_____

List any environmental, supplemental and food allergies you have and the type of reaction that occurs.

_____
_____
_____

Describe any health issues/problems you are currently experiencing. Specify your main concern.

_____
_____
_____
_____

Section 4

How many coffees do you have per day?
_____

How many black teas do you have per day?
_____

How many soft drinks do you have per day?
_____

How many alcoholic drinks do you have per day/wk?
_____

How many ounces of water do you drink per day?
_____

Do you use a water filter? Which kind?
_____

Do you crave chocolate?
_____

How many fruits do you eat per day?
_____

Do you eat organic?
_____

Where do you eat the majority of your meals?
_____

Do you follow a specific diet? (paleo, vegan, etc)
_____

Do you crave certain foods? Name them
_____

Do you avoid certain foods? Name them and reason why.

_____

Provide any additional information that may be relevant but hasn't been covered in regard to diet.

_____
_____
_____

Section 5

Do you use any fluorescent lights at work or home?
_____

Do you use a computer? Hours spent on it per day?
_____

Do you use a cell phone? Hours spent on it per day?
_____

How often do you travel by plane?
_____

Do you use a microwave?
_____

Any high tension lines near your work or home?
_____

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Section 6

How many hours do you work per week?

_____

How many hours do you sleep per night?

_____

Do you wake up in the night? How often?

_____

What time do you go to bed?

_____

Is bed time the same time every night?

_____

Where do you fall asleep?

_____

Do you feel well rested upon rising?

_____

Do you take naps throughout the day?

_____

If yes to waking up at night, what is the reason?

_____

Do you have any time for yourself?

_____

What do you do for fun?

_____

List any hobbies you take part in

_____

Section 7

Where did you live growing up? (City, Country)

_____

What is your occupation?

_____

How many cigarettes do you smoke per day?

_____

How many metal fillings do you have?

_____

Date of most recent removal?

_____

Date of most recent root canal?

_____

Do you or have you used aluminum cookware?

_____

Do you use antacids?

_____

Ever been on hormone replacement therapy (HRT)?

_____

Have you ever had vaccinations? (flu shots included)

_____

Have you ever been on antibiotics?

_____

How often do you take antibiotics?

_____

What are the reasons you take antibiotics?

_____

What was the date of your last prescription?

_____

What type of environment do you work in? ex-office.

_____

How many years have you smoked for?

_____

If you quit smoking, how long ago?

_____

Any history of second hand smoke?

_____

Have you had any metal fillings removed/how many?

_____

How many root canals do you have?

_____

Do you use antiperspirants that contain aluminum?

_____

If you stopped taking HRT, how long ago was this

_____

If yes to HRT, how long were you on this medication?

_____

Do you dry clean your clothes?

_____

Any home renovations within the last 12 months?

_____

Do you use natural products? (ex-shampoo, etc)

_____

What household products are you exposed to? Check which ones.

Bleach ( ) Toilet cleaners ( ) Air freshener ( ) All purpose cleaners ( ) Lawn or gardening chemicals ( ) Other chemicals ( )

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