Flavorfulfit

Intake Questionnaire

Personal Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Height, Weight , Age

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Have you ever taken antibiotics? ○ Yes ○ No

Have you ever taken birth control? ○ Yes ○ No

Have you ever been on hormone replacement therapy? ○ Yes ○ No

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

List your current health concerns in order of importance

Health Concerns

Do you experience digestive difficulties?

(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement? ◯ Yes ◯ No

Are your bowels loose? ◯ Yes ◯ No

Do you take laxatives? ◯ Yes ◯ No

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Do you avoid these foods? ◯ Yes ◯ No

Diet

How much water do you drink daily?

Do you consume coffee? ○ Yes ○ No

Do you consume tea? ○ Yes ○ No

Do you consume alcohol? ○ Yes ○ No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Do you experience any symptoms after meals?

Describe your relationship with food

Please be very specific

Are you working with a nutritonist or Dietitian , personal trainer etc in terms of nutrition? If yes whom?

Have you tried other diets? If so explain which and why they haven't worked for you.

Do you eat out often

◯ Yes ◯ No

Do you think you suffer with emotional eating, binging or any other eating disorder? If Yes please explain more in detail.

List any foods that you crave regardless of their nutritional value (includes chocolate, sweets, sour, salty, bread, rich/fatty food):

If you are breastfeeding leave information below. How many times ? Hows your sleep etc

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? You wake frequently during the night?

Do you wake feeling rested? ◯ Yes ◯ No

How often do you exercise?

What types of exercise do you do? and do you have any injuries..

What do you do to have fun?

How do you express your creativity?

Do you have any pets? ◯ Yes ◯ No

What level of stress are you currently experiencing?

List your main stressors

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

How many hours per day do you use a computer?

How many hours per day do you use a cell phone?

How many hours per day do you use watch TV?

Chemicals

Where did you grow up?
City or country?

◯ City ◯ Country

What type of environment do you/ have you worked in?

How many cigarettes do you smoke per day?

For how many years? If you quit, how long ago?

Do you or have you used recreational drugs?

◯ Yes ◯ No

Have you had any dental work done?
Do you have fillings (metal), root canals, crowns, etc?

Have you ever had shots/vaccinations?
List all that apply (including flu shots)

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

1 = Lowest, 10 = Highest

Is your home well ventilated or were you ever exposed to mold?

Have you or you family recently experienced any major life changes or trauma?

Do you feel safe, respected, and valued in your current relationship?

Do odors or body products affect you? if so, which ones?

Have you ever had psychotherapy or counseling? ○ Yes ○ No

It is common practice for nutritionists and other non-licensed practitioners to collect your signature on a liability waiver form such as this. By doing so you acknowledge that it is your responsibility to deliver all laboratory results, now and in the future, to your own physician for any medical interpretation or opinion regarding any laboratory results provided by flavorfulfit. Check to agree to each of the following before submitting:

- ☐ I understand and acknowledge that FlavorFul FIT INC. Trademarked is an approach to health and weight loss-focused wellness and fitness for people in good health, and not a medical, nutrition, or diet program, and that its Accountability Coach are not licensed health professionals and have no healthcare training. I understand that Coaches focus only on proper nutrition and weight loss and maintenance goal, not other personal issues.
- ☐ I agree to seek the clearance of a physician or qualified medical professional to manage my health and determine if FLavorfulFIT™ and its components are appropriate for me. I understand that I should not apply for FlavorfulFIT™ if I have a medical condition that would limit my ability to restrict my eating or to exercise vigorously on a daily basis.
- ☐ I understand that Flavorfulfit does not diagnose, cure or treat any illness or disease. I release Flavorfulfit from any and all liability for any failure to identify any medical conditions or disease.
- ☐ I understand that my success participating FlavorfulFITi™ depends upon my commitment. I am ready, willing, and able to devote the time needed to complete and fulfill the Program. I agree to responsive and cooperate in meeting the ongoing requirements of participation in FlavorfulFIT™ in a timely manner.
- ☐ Upon paying and signing up to the program I cannot request a refund after documents are sent out to me.

Gut Health

(Not present=0 severe and or experience regularly =10)

Excess Gas	
Bloating	
Diarrhea	
Constipation	
Indigestion	
Acid Reflux/GERD	
Heartburn	
Abdominal Pain	
Brain Fog	
Skin Issues(Psoriasis, Acne, Rosacea)	
Below 20 mild, Moderate 40 above Severe 41	

Liver and Gallbladder

Alcohol Intolerance	
sensitive to fumes and fragrances	
caffeine sensitivity	
nausea from fatty meals	
floating stool	
pain between shoulder blades	
Motion Sickness	
Dry Skin	
Mild=15 Moderate=35 Severe=36 more TOTAL:	

Sex Hormone Balance

Low Libido	
Weight Gain	

Stubborn Lower Body fat	
Fluid Retention(puffy)	
Mood Swings	
Oily Skin / Acne	
Irritability	
Unwanted hair growth	
Decreased Muscle Strength or SIze	
Infertility	
Mild=20 Moderate=40 Severe=41 TOTAL:	

Hormone Balance

PMS	
Heavy or irregular period	
Breast Tenderness	
Vaginal Dryness	
Breast Cysts, Fibroids	
Endometriosis	
Hot Flashes	
Nigh Sweats	
Miscarriages	
Mild=20 Moderate=20 Severe=41 TOTAL:	

Thyroid Function

Weight Gain	
Weight Loss resistance	
Fatigue	
brain sluggishness	
Cold often	
Unwanted hair loss	
flush easily	

high cholesterol	
chronic constipation	
get hot or cold easily	
mild=20 Moderate=40 Severe=41 TOTAL:	

Adrenal Function

Feel wired but tired	
difficulty waking and getting out of bed	
tend to be a night person	
afternoon fatigue	
racing thoughts and trouble calming down	
insomnia poor sleep	
high blood pressure	
low blood pressure	
dizzy upon standing	
salt cravings	
sweet cravings	
Mild=20 Moderate=40 Severe=41 TOTAL:	

Blood Sugar Balance

Wake up in middle of night	
thirsty in the middle of the night	
binge eating	
sugar cravings	
get hangry between meals	
headache between meals	
frequent thirst or urination	
crave caffeine	
shaky between meals	

nausea and sweating if meals are delayed	
light headed if meals delayed	
fatigue relieved by meals	
mild=25 Moderate=45 Severe=46 TOTAL:	

Nutrient Deficiencies

Racing Heart	
Exercise Intolerance or Fatigue Easily	
Difficulty recovering from activity	
Cracked Brittle Nails	
Pale Skin	
Nose Bleeds	
Bruise Easily	
Restless Leg syndrome	
Numbness or tingling	
Ringing in Ears	
Cracks at corner of mouth	
Bleeding gums	
Shortness of Breath	
dizziness	
Mild=30 Moderate=55 Severe=56 TOTAL:	

Neurotransmitter Balance

Depression	
Seasonal affective disorder	
Anxiety	
OCD	
Brain Fog	
Poor memory	

Low self esteem	
Inability to focus or finish tasks	
Difficult Learning	
Lack of pleasure	
Carb sugar cravings	
binge eating	
feelings of apathy or indifference	
lack of joy	
irritability	
feelings of overwhelm	
dark thoughts	
Mild=30 Moderate=60 Severe=61	

Flavorfulfit

Assumption of Risk and Release of Liability

I hereby acknowledge and agree:

1. The purpose of nutritional counselling is to improve the overall health, vitality and well-being of the body through nutritional education and the use of natural foods and non-medicinal nutritional supplements. The **Health Practitioner**, **Eve scaba**, does not diagnose diseases, disorders or conditions.

2. The **Health Practitioner**, **Eve scaba**, is not a licensed Dietitian, Naturopathic Doctor or Medical Physician.

3. As part of the Nutritional Counselling Services, I may be asked to provide information concerning my physical habits, medical history, moods, energy levels, likes and dislikes, lifestyle and diet. This information is collected to enable the **Health Practitioner** to: (i) assess my knowledge of nutrition, (ii) education me about the benefits of sound nutritional practices and (iii) recommend dietary changes to improve my general health, vitality and overall

well-being. The **Health Practitioner**, **Eve scaba** will hold this information in confidence and will not release or disclose this information to any other person, without my prior consent, except as required by applicable law.

4. If the **Health Practitioner**, **Eve scaba,** suspects the existence of disease, disorder or condition, I will be informed of this suspicion. However, I acknowledge this is not a diagnosis or conclusion about the state of my health and that I am directed to promptly consult a licensed Physician or Naturopath about any suspected problems.

5. Should I request the **Health Practitioner**, **Eve scaba**, to recommend dietary changes and/or nutritional supplements to enhance my body's natural ability to resist and/or overcome a known disease, disorder or condition, it is my responsibility to disclose the nature of the disease, disorder or condition and all other relevant details to the **Health Practitioner**, **Eve scaba**. If I have not previously consulted a licensed Physician or Naturopath about this disease, disorder or condition, I acknowledge that I am directed to promptly do so. I am not to alter or discontinue treatments prescribed by a licensed Naturopath, Physician or other licensed health professional without consulting the individual who prescribed the treatment.

6. In providing Nutrition Counselling Services to me, the **Health Practitioner**, **Eve scaba**, is relying upon the truth, accuracy and completeness of all information I have provided to her. Any recommendations I follow for changes in diet, including the use of nutritional supplements, are entirely my responsibility.

7. **Eve scaba** is in no way liable for my health or safety.

8. In consideration of my participation in the **Nutritional Counselling Services**, I hereby accept all risk to my health, including injury or death that may result from such participation and I hereby release the **Health Practitioner**, **Eve scaba**, on my behalf and on behalf of my personal representatives, estate, heirs, next of kin, and assigns from any and all costs, claims, causes of action and damages arising from any and all illness or injury to my person, including my death, that may result from or occur as a result of my participation in the **Nutrition Counselling Services**, whether caused by negligence or otherwise.

9. **%NUMBER_OF_HOURS%** is required for cancelling appointments. Appointments cancelled within **%NUMBER_OF_HOURS%** of your appointment time, you will be billed at **%PERCENTAGE%**.

10. I understand that any therapies I undertake at **Flavorfulfit** are undertaken of my own free will. I accept that the ultimate responsibility for my health care is my own and that **Flavorfulfit** is here to support me in this. I understand that my practitioner reserves the right to determine which cases fall outside their scope of practice, in which event an appropriate referral will be recommended. I hereby agree to assume full responsibility for any manner of loss, injury, claim or damage whatsoever, known or unknown, incurred as a result of same and I, my heirs, executors, administrators or assigns for any loss, injury, claim or damage sustained as a result of my attendance and/or participation. I have read the above release and waiver of liability, and fully understand its contents and voluntarily agree to the terms and conditions stated.

Client Signature

I HAVE CAREFULLY READ THIS AGREEMENT AND AGREE TO THE TERMS OUTLINED ABOVE. I UNDERSTAND THIS AGREEMENT TO BE A FULL AND FINAL RELEASE OF ALL COSTS, CLAIMS, CAUSES OF ACTION AND DAMAGES OF ANY KIND ARISING FROM OR IN CONNECTION WITH THE **NUTRITION COUNSELLING** SERVICES.

X

Print name: **Date:**