



Angela Wright, BSc, CNP, RNCP Holistic Nutritional Consultant
(250) 451-9208 - ange@alignnutrition.com - www.alignnutrition.com
Orchard Chiropractic & Wellness – appointments call (250) 717-7732
The Woman’s Place Fitness Group – appointments call (250) 762-7255

New Client Intake Form

Name:

Date of Birth:

Address:

Phone#(s):

Email:

Height:

Present Weight:

Your Ideal Weight:

How did you hear about our services?

Why are you seeking nutritional consulting? Summarize yourself health-wise.

List your main concerns or symptoms. How long have these been issues?

List your main goals to get you to the ideal person you want to become.

Finish this sentence - "I haven't felt the same since....."

Symptoms and Overall Health

Other health practitioners/doctors you are seeing/have seen recently and why

Please list any drugs (prescription, over-the-counter, recreational) you are taking/have recently

Please list any supplements (vitamins, minerals, herbs, homeopathics, etc) you are taking

Please check any issues below that apply to you

Constipation (fewer than 1 bowel movement a day)	
Diarrhea	
Acid reflux, indigestion, heartburn, GERD,	
Excessive gas, belching or burping	
Stomach cramping, irritable or spastic bowel	
Hemorrhoids, varicose veins	
Urgent or frequent urination	
Experience hunger almost constantly	
Feel unwell if don't eat regularly, miss a meal	
Feel better when don't eat	
Craving for salt	
Craving for sweets or starches	
Craving for chocolate	
Crave or consume daily tobacco/alcohol/caffeine	
Cardiovascular disease / blood pressure/cholesterol	
Heart palpitations or irregular heartbeat	
Headaches, migraines	
Back pains, neck pains	
Arthritis, joint pains	
Physical /Repetitive Injury	
Osteoporosis / Osteopenia	
Anemia, low iron	
Lightheadedness or dizziness	

Nausea, vomiting	
Dry / leathery skin, dry hair	
Skin bruises easily	
Wounds heal poorly, slowly	
Thyroid issues	
Low body temperature	
Cold hands or feet	
Gain weight easily, sluggish metabolism	
Lose weight easily, fail to gain weight	
Hyperactivity	
Dry / inflamed eyes, discharge	
Eyes sensitive to light	
Ringing in ears, tinnitus	
Frequent colds, sniffles	
Frequent infections: virus / bacterial / ear / sinus / other	
Yeast infections	
Asthma / Bronchitis	
Acne / Eczema / Psoriasis / Hives /Rashes	
Auto-immune Disease	
Antibiotic use	
Formula Fed or Caesarian Birth	
P.M.S., menstrual cramping, clotting, dysmenorrhea	
Endometriosis, PCOS	

Birth Control Pills or Devices	
Peri-menopausal Symptoms	
Decline in sexual interest, feelings, ability	
Mood swings	
Anxiety, easily startled	
Irritability	
Depression	
Perfectionist	
Tightness in throat when emotional	
Low self confidence	
Easily distracted, difficulty concentrating	
Periods of "foggy" or "fuzzy" thinking; staring or "stunned" feeling	
Bothered by chemical or perfume odors	
Food or Environmental Allergies or Intolerances	
Disordered Eating	
Teeth - silver fillings, fillings removed, root canals	
Insomnia / Frequent Waking	
Liver / Gallbladder problems	
Diabetes / Hypoglycemia	
Cancer	
Surgery/ Removed Organs (gall bladder, tonsils, uterus, appendix, etc.)	

Please elaborate and add other diagnoses or issues that you have / have had in the past.

What major health issues run in your family?

Describe a typical day/week's bowel pattern (frequency, constipation/diarrhea, hard/soft, easy/painful). Are there specific foods that effect your digestion? Effected by stress?

Females: Describe your menstrual cycle and any complications or symptoms associated.

Describe your energy levels. Do you get tired, fatigued, or lack energy over the day?

Sleep – how many hours/night? Do you wake in the night? Do you wake feeling rested?

Rate your stress level (1-10). Main sources (work, money, family, health, etc)? How do you deal?

What is your present activity level and schedule? What kind of exercise? Duration?

Do participant in any mindful or stress relieving activities - meditation, yoga, journaling, prayer?

What is your present occupation? Former occupations? Work schedule? Activity level at work?

Living situation? Family, roommates, etc? Who do you eat with or influences your eating choices? Who does the grocery shopping? Who does the cooking? How often do you cook?

Dietary Choices and Eating Habits 🥑

Tell me about your regular food choices and eating habits. Please elaborate where possible.

Meal pattern (i.e. breakfast in car, bagged lunch at desk, snack when in the door, dinner with family, etc). What do you like for/typically have for breakfast, lunch, dinner, and snacks? Do you have a tendency to skip meals? How often do you eat out? Do you graze?

Food weakness or cravings? (carbs, fried, spicy, alcohol, sugar, baking, chocolate, salty, etc.)

Tell me about your liquid intake; how much water, what other beverages? coffee, pop, alcohol?

Do you eat...	Daily	Rarely	Never	Allergy/ sensitivity – please list
Vegetables				
- salad, raw				
Fruit				
Beans & Legumes				
- soy				
- peanuts & p/butter				
Nuts & Nut Butters				
Seeds & Seed Butters				
Grains				
- white bread/ pasta/rice/flour				
- whole grains & whole grain products				
- wheat				
- other glutinous grains (barley, rye, spelt, kamut)				
- gluten free grains (rice, quinoa, millet, teff, amaranth, corn)				
Dairy – all				
- cow's milk				
- cow's yogurt				
- cow's cheese				
- goat's dairy				
Dairy substitutes (almond/rice/oat/ hemp/soy/coconut)				
Animal Protein				
- red meat				
- fish and shellfish				
- poultry and pork				
- eggs				
Fats & Oils				

Do you eat...	Daily	Rarely	Never	Allergy/ sensitivity – please list
- butter				
- margarine				
- olive oil, grape seed oil, coconut oil				
- vegetable oil, canola, corn oil, PAM				
Sweeteners				
- white sugar, table syrup, brown sugar				
-artificial sweeteners, aspartame, Splenda				
- honey, maple syrup, agave syrup, stevia				
Spices, Condiments, & Dressings				
- table salt				
- sea salt				
- low fat mayo, low fat dressings				
Snacks				
- chips, candy, chocolate bars, granola bars				
Fast Food/Take Out				
- burgers, fries, pizza				
- sushi, salads				
Dining Out/Sit Down				
Beverages				
- water				
- pop regular & diet				
- alcohol				
- coffee, black tea, caffeine beverages				
- decaf, herbal tea, green tea				



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5 Day Food and Mood Intake Form (please include a minimum of 1 weekend day; include time of meal and physical activity)

Day/Date Meal/Snack					
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
Snack					
Liquids (w/amount)					
Bowels/ Digestive					
Mood/ Emotions/ Sleep/Energy					







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Align Nutrition - Operational Guidelines

-  As a Nutritional Consultant, **Angela Wright** is not a medical doctor. She is not legally permitted to diagnose diseases or conditions. For the diagnosis or treatment of any ailment, please consult a licensed physician. **Angela Wright** can, however, give guidance about giving your body the nutrients it needs to bring itself back into balance, regardless of what state it may be in. Her role in your health care is to advise you in building and maintaining wellness.




Informed Consent

-  I fully understand that **Angela Wright** is not a medical doctor and I am not here for medical diagnostic or treatment procedures.
-  I am here on this and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial, municipal, or professional agency on a mission of entrapment or investigation.
-  I understand that the services performed by **Angela Wright** are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health, and do not involve the diagnosing, prognosticating, or prescribing of remedies for the treatment of disease.
-  I understand that part of the risk involved in undertaking any activity is relative to my own state of fitness and health (physical, mental, and emotional) and the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that it is my choice to participate in any activity program or service suggested by **Angela Wright**. I also acknowledge that I have inquired about the nature of any activity, program, or services that I am not completely familiar with and I have been informed of any inherent risks.

Cancellation and Missed Appointment Policy

Everyone is aware of the value of time. As my time is valuable as well as yours, please abide by the following policy.

Cancellation of appointments must be made at least 24 hours in advance of scheduled appointments to avoid late fees. Missed appointments or cancellations within 24 hours of scheduled appointment will incur a flat rate as follows -

- | | | |
|---|---|------------------------------|
|  | First missed or late re-scheduling of appointment | warning |
|  | Second late re-scheduling of appointment | ½ \$ value of appointment |
|  | Second missed appointment | full \$ value of appointment |

I declare that I have read, understood, and agree to the contents of this informed consent agreement in its entirety.

Signature: _____

Name (please print): _____

Date: _____