# Chelsey Love Nutrition.

*Create healthy habits, not restriction.*

| **Original Date:** |
|---|
| **Dates Revised:** |

# NUTRITION AND LIFESTYLE QUESTIONNAIRE

| | | |
|---|---|---|
| **Name:** □Male □Female | | **Birthday:** |
| **Email:** | | **Phone number:** |
| **Marital status:** | **How did you hear about us?** | |
| **Family doctor:** | **Date of last check up with doctor/bloodwork:** | |

## PERSONAL HEALTH & NUTRITION HISTORY

**Main nutrition & lifestyle goals:**

| Height: | Current Weight: | Highest Weight: | Goal Weight: |
|---|---|---|---|

**Has your weight fluctuated in your adult life? If so, please describe your weight history:**

**Check any conditions that apply to you or describe any others.**

| | | |
|---|---|---|
| Anxiety | Gallstones | Liver Disease |
| Anemia / Low Iron | Gout | Lupus |
| Cancer Type: | Grave's Disease | Menopause |
| Celiac Disease | Heart Disease | Multiple Sclerosis |
| Cholesterol High LDL | Heartburn / Reflux | Nut Allergy |
| Cholesterol Low HDL | Hepatitis | Pancreatic disease |
| Triglycerides High | Hiatal Hernia | Pregnancy |
| Colitis | Hypertension (High Blood Pressure) | Rheumatoid Arthritis |
| Crohn's | Hypoglycemia | Shortness of Breath |
| Daytime sleepiness | Hypothyroidism | Sleep Apnea |
| Depression | IBS (Irritable Bowel Syndrome) | Swelling in feet/ankles |
| Diabetes Type 1 | Kidney Stones | Ulcers |
| Diabetes Type 2 | Lactation (Breastfeeding) | Vertigo |
| Eating Disorders Type: | Lactose Intolerant | Other: |
| Fibromyalgia | Latex Allergy | Other: |

| | | |
|---|---|---|
| **Do you authorize your dietitian to contact and share your progress with your medical team?** | ☐ Yes | ☐ No |

| List any other medical conditions or concerns: |
|---|
| |

| List your prescribed drugs, over-the-counter drugs, and supplements such as vitamins/minerals | | |
|---|---|---|
| Name of medication or supplement | Dose | Frequency Taken |
| | | |
| | | |
| | | |
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| | | |
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| | | |

| Allergies / Sensitivities | |
|---|---|
| Name the food(s) | Reaction You Had/Have |
| | |
| | |
| | |
| | |
| | |
| | |

| Are there any other foods you avoid for any reason? Describe: |
|---|
| |

| Describe your regular nutrition routine, including meals, snacks, drinks, time of day, and approximate portion size: |
|---|
| |

| HEALTH HABITS | | | | | | |
|---|---|---|---|---|---|---|
| **Exercise** | ☐ Sedentary (Example: your job is sedentary/desk job. No regular planned exercise. You do activities of daily life, and may enjoy walking or light biking occasionally)<br>Describe: | | | | | |
| | ☐ Light exercise (Example: your job is sedentary or lightly active. You incorporate planned exercise regularly 1-2x/week)<br>Describe: | | | | | |
| | ☐ Moderate exercise (Example: your job may be lightly active or active. You enjoy being active regularly and plan moderately intense exercise 3-5x/week)<br>Describe: | | | | | |
| | ☐ Vigorous exercise (Example: your job may be active or very active. You regularly challenge your body and plan intense exercise 5-6x/week or more)<br>Describe: | | | | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | | |
| | # of cups/cans per day? | | | | | |
| **Alcohol** | Do you drink alcohol? | | | | ☐ Yes | ☐ No |
| | If yes, what kind? | | | | | |
| | How many drinks per week? | | | | | |
| | Are you concerned about the amount you drink? | | | | ☐ Yes | ☐ No |
| | Are you thinking of reducing the amount that you drink? | | | | ☐ Yes | ☐ No |
| | Do you "binge" drink? If so, describe: | | | | ☐ Yes | ☐ No |
| **Tobacco** | Do you use tobacco? | | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks./day | | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | ☐ Or year quit | | | | |

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | | |
| **Mother** | | | | | |
| **Sibling** | | | | | |
| | | | | | |
| | | | **Grandmother** *Maternal* | | |
| | | | **Grandfather** *Maternal* | | |
| | | | **Grandmother** *Paternal* | | |
| | | | **Grandfather** *Paternal* | | |

## MENTAL HEALTH, STRESS, SLEEP

| | | |
|---|---|---|
| Is stress a major problem for you? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? | ☐ Yes | ☐ No |
| Do you believe you eat too little when you're stressed? | ☐ Yes | ☐ No |
| Do you believe you eat too much when you're stressed? | ☐ Yes | ☐ No |
| Have you ever felt "out of control" with your eating? | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Do you relate to being an "emotional eater?" | ☐ Yes | ☐ No |
| Have you ever binged, or purged your food after eating? | ☐ Yes | ☐ No |
| Have you ever been to a counselor or psychologist? | ☐ Yes | ☐ No |
| Would you like a referral to a counselor or psychologist? | ☐ Yes | ☐ No |

## DIGESTIVE HISTORY

Check if you have any symptoms in the following areas:

| | | | |
|---|---|---|---|
| ☐ | Heartburn | ☐ | Stomach Pain |
| ☐ | Excess Gas | ☐ | Nausea |
| ☐ | Bloating | ☐ | Vomiting |
| ☐ | Diarrhea | ☐ | Constipation |

# Chelsey Love Nutrition General Release and Membership Agreement

**1. Disclaimers**

1.1 I understand that Chelsey Love, RD is a Registered Dietitian/Nutritionist , and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical doctor.

1.2 If the Client is under the care of a health care professional or currently uses prescription medications, the Client should discuss any dietary changes or potential dietary supplements use with his or her doctor, and should not discontinue any prescription medications without first consulting his or her doctor.

1.3 The Client acknowledges that the care that they receive during their health coaching sessions is separate from the care that they receive from any medical facility in that the nutrition coaching sessions are in no way intended to be construed as medical advice or care. The Client should continue regular medical supervision and care by their primary care physician.

**2. Personal Responsibility and Release of Health Care Related Claims:**

2.1 The Client acknowledges that the Client takes full responsibility for the Client's life and well-being, as well as the lives and well-being of the Client's family and children (where applicable), and all decisions made during and after the duration of the client's wellness sessions.

2.2 The Client expressly assumes the risks of nutrition coaching sessions, including the risks of trying new foods, and the risks inherent in making lifestyle changes.

2.3 The Client releases the Dietitian/Nutritionist and Chelsey Love Nutrition from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law or equity, which the Client ever had, now has or will have in the future against the Dietitian/Nutritionist, arising from the Client's past or future participation in, or otherwise with respect to, the nutrition sessions, unless arising from the gross negligence of the Dietitian/Nutritionist.

**3. Confidentiality**

3.1 The Dietitian/Nutritionist will keep the Client's information private, and will not share the Client's information to any third party unless compelled to by law or with the consent of the Client.

**4. Payments and Refunds**

4.1 Payments are due at the time of service for the initial consultation, and payments are due prior to follow up appointments. There are no refunds for payments made to Chelsey Love Nutrition.

4.2 Packages are to be paid in full at the time of the initial assessment.

**5. No-Show/Cancelation Policy**

5.1 In the event that the client does not show up to an appointment or cancels within 24 hours of a scheduled appointment the Dietitian/Nutritionist and/or Chelsey Love Nutrition reserves the right to charge the client 100% of the session payment fee. Late cancellation or no show fee is due before the next appointment is scheduled. If the appointment was part of a package, the appointment may be deducted from the program as if it was completed.

5.2 The above clause may be disregarded in the event of an emergency, at the discretion of the Dietitian/Nutritionist.

5.3 Clients will not be able to claim missed or cancelled appointments through their health benefits, and the Dietitian/Nutritionist cannot issue an insurance receipt for missed or cancelled appointments.

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

_____ (Date)

_____ (Client Signature)

_____ (Client Name)

_____ (Witness)

_____ (Witness Name)