Keenist
HOLISTIC NUTRITION

WOMEN'S HEALTH HISTORY

Please write or print clearly. All of your information will remain confidential between you and Stephanie.

Personal Information

First Name: _____ Last Name: _____

Email: _____ Cell Phone: _____

Age: _____ Height: _____

Current weight: _____ Six months ago: _____ One year ago: _____

Would you like your weight to be different?_____ If so, what?_____

Social Information

Where do you currently live?_____

Occupation: _____ Hours per week: _____

Relationship Status: _____ Children: _____ Pets: _____

General Health

Please list your main health concerns: _____

_____

Other concerns and/or goals?_____

_____

At what point in your life did you feel best?_____

_____

Keenist
HOLISTIC NUTRITION

Any pain, stiffness or swelling?_____

_____

Any serious illnesses, hospitalizations, or injuries?_____

_____

What blood type are you?_____

_____

Do you take any supplements or medications? Please list: _____

_____

What role do sports and exercise play in your life?_____

_____

On average, how many hours do you sleep each night? _____ Do you have trouble falling sleep? _____

Do you wake up throughout the night? _____

Digestive Health

Do you have a bowel movement daily?_____

Do you experience constipation regularly?_____

Do you experience diarrhea regularly?_____

Do you get gassy and bloated frequently?_____

Keenist
HOLISTIC NUTRITION

Do you get heartburn or acid reflex?_____

Do you have food sensitives or allergies? If so, to what foods?_____

Women's Heath

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

Birth control history: _____

Reached or approaching menopause?_____

Do you experience yeast infections or urinary tract infections? _____

Food Information

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Is there anything special about your diet I should know? _____

Do you cook? _____ What percentage of your food is home-cooked? _____

Do you crave sugar, salt, coffee or alcohol? _____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Keenist
HOLISTIC NUTRITION

Additional Comments

The most important thing you think you should do to improve your health is: _____

_____

Anything else you would like to share? _____

_____

_____

_____

Miscellaneous

How did you discover my practice?_____

Can I add you to my e-mail list (only used to distribute blog posts, recipes, etc.)?_____

DISCLOSURE AND WAIVER OF LIABILITY AGREEMENT

I, the undersigned ("Client"), acknowledge that I have read and understand the contents of this liability agreement.

1. Stephanie Rome is a nutrition consultant and does not function as a physician, diagnose or treat disease, nor do her services replace the necessary services of a licensed physician.

2. Stephanie Rome makes no representations, claims, or guarantees regarding the efficacy of her recommendations. The recommendations are based upon a combination of her nutrition and health coaching education and knowledge of natural health literature. A nutrition consultation as provided by Stephanie Rome does not constitute a medical service or health

care treatment.

3. I understand that the nature of the recommended treatments for my care will be explained to me and that I will have the opportunity to ask questions of those involved in my care. I am not being forced to accept treatment.

4. Individualized recommendations are offered and applied as an educational and informative consultation. Any action taken as a result of the consultation is done at the sole discretion and risk of Client. Therefore, it is strongly recommended that in addition to any health consultation that you maintain a relationship with one or more physicians qualified to care for health condition(s). For example, in the case of children you are advised to seek the advice of a pediatrician; if you have cardiovascular disease, consult with a cardiologist; and if you have cancer, consult with an oncologist, etc.

5. Client's signature verifies that Client has not been told to discontinue treatments with any other medical specialists or other health care providers. Client's signature is being given prior to rendering any service, advice, and/or recommendations whatsoever.

6. Financial Policy: Patients are fully responsible for all professional services received. Client is not contracted with insurance companies and does not bill for services. I, the undersigned, understand that I am responsible for all charges.

By signing below, you agree to comply with the above polices and acknowledge that you understand all terms, verbiage (language) and concepts herein. Furthermore, Client agrees not to hold Stephanie Rome liable for any costs or damages related to the services provided other than for willful misconduct or gross negligence.

I understand this consent agreement and have executed it freely and willingly.

Client Signature: _____

Printed Name: _____

Date: _____