Cindy A. Mimo, MS, Clinical Nutritionist
My Life Nutrition, LLC

# Client Intake Form

**Personal Information**

| | | |
|---|---|---|
| Name: | | Date: |
| Birthdate: | Age: | Gender: ☐F ☐M |
| Address: | | |
| If a minor, provide parent name(s): | | |
| Email: | | |
| ☐Home Phone: | ☐ Work Phone: | ☐ Cell Phone: |
| *Check box for preferred phone number to contact you* | | |
| Employer/Occupation: | | |
| Ethnic background: | | |
| Relationship status: ☐Married ☐ Single ☐Divorced ☐ Widow/ Widower ☐ Other:_____ | | |
| Emergency Contact Name & Phone number: | | |
| Do you have children? ☐Y ☐N How many and ages? | | |
| Do you have pets? ☐Y ☐N What type and how many? | | |
| Primary Care Physician name and phone: | | |
| How did you hear about me? ☐Workshop/ Seminar ☐Brochure/ Business Card ☐ Website<br>Referred by: _____ | | |

**Your Health & Wellness Goals**

| |
|---|
| Is there a specific health and wellness factor that brings you to this nutritional consultation today? |
| What are your primary health and wellness goals and/ or concerns? |
| What would you like to accomplish regarding your health & wellness short term (1-6 months)? |
| What would you like to accomplish regarding your health & wellness longer term (6 months-1 year)? |
| Have you previously utilized nutritional or lifestyle protocols for the betterment of your health and wellness, and if so what were they and what were your results? |
| Are there any obstacles or challenges that you believe may make it difficult to achieve your health and wellness goals? |

Cindy A. Mimo, MS, Clinical Nutritionist
My Life Nutrition, LLC

***Indicate below if you or a family member have, or had, any of the following conditions:***

| Condition | Self | Family | Condition | Self | Family |
|---|---|---|---|---|---|
| **Cardiovascular** | | | **Muscular, Skeletal, Joints** | | |
| -High blood pressure | ☐ | ☐ | -Back pain | ☐ | ☐ |
| -High cholesterol | ☐ | ☐ | -Joint Pain, stiffness, swelling | ☐ | ☐ |
| -Heart attack or stroke | ☐ | ☐ | -Frequent muscle cramps | ☐ | ☐ |
| -Arrhythmia | ☐ | ☐ | - Arthritis, Rheumatoid | ☐ | ☐ |
| **Digestive/ Gastrointestinal** | | | -Arthritis, Osteoarthritis | ☐ | ☐ |
| -Low appetite | ☐ | ☐ | -Osteoporosis/Osteopenia | ☐ | ☐ |
| -Constant hunger | ☐ | ☐ | **Endocrine** | | |
| -Constipation | ☐ | ☐ | -Diabetes Mellitus Type 1 | ☐ | ☐ |
| -Diarrhea | ☐ | ☐ | -Diabetes Mellitus Type 2 | ☐ | ☐ |
| -Frequent gas, bloating or cramping | ☐ | ☐ | -Metabolic Syndrome | ☐ | ☐ |
| -Acid reflux/heart burn/indigestion | ☐ | ☐ | -Hyperglycemia | ☐ | ☐ |
| -Frequent nausea | ☐ | ☐ | -Hypoglycemia | ☐ | ☐ |
| -Hiatal hernia | ☐ | ☐ | -Thyroid disorder | ☐ | ☐ |
| -Celiac's disease | ☐ | ☐ | -Adrenal disorder | ☐ | ☐ |
| -IBD, Crohns or Ulcerative Colitis | ☐ | ☐ | **Liver** | | |
| -Irritable Bowel Syndrome IBS | ☐ | ☐ | -Hepatitis | ☐ | ☐ |
| **Genital/Urinary** | | | -Cirrhosis | ☐ | ☐ |
| -Frequent yeast infections | ☐ | ☐ | **Viral/ Bacteria Infections** | | |
| -Urinary tract infections | ☐ | ☐ | -HIV/AIDS | ☐ | ☐ |
| -Urinary incontinence | ☐ | ☐ | -Sexually Transmitted Disease | ☐ | ☐ |
| -Kidney disease | ☐ | ☐ | -Lyme disease or other tick borne | ☐ | ☐ |
| **Neurological/ Mental Status** | | | -Frequent strep throat | ☐ | ☐ |
| -Anxiety or Depression | ☐ | ☐ | **Other Conditions** | | |
| -Headaches/ Migranes | ☐ | ☐ | -Food allergies or sensitivities | ☐ | ☐ |
| -Dementia/ Alzheimer's | ☐ | ☐ | -Seasonal or environmental allergies | ☐ | ☐ |
| -Mutiple Sclerosis (MS) | ☐ | ☐ | -Chemical sensitivity | ☐ | ☐ |
| -Fibromyalgia | ☐ | ☐ | -Anemia/ blood condition | ☐ | ☐ |
| **Respiratory/ ENT** | | | -Alcohol or substance abuse | ☐ | ☐ |
| -Sinusitis | ☐ | ☐ | -Epilepsy or seizures | ☐ | ☐ |
| -Ear infections/ tubes in ears | ☐ | ☐ | -Eating disorder | ☐ | ☐ |
| -Chronic obstructive pulmonary disease (COPD) | ☐ | ☐ | -Skin condition (eczema, dermatitis, psoriasis, acne) | ☐ | ☐ |
| -Chronic bronchitis | ☐ | ☐ | -Obesity/ overweight | ☐ | ☐ |
| -Asthma | ☐ | ☐ | -Unexplained weight gain or loss | ☐ | ☐ |
| -Emphysema | ☐ | ☐ | -Gout | ☐ | ☐ |
| -Frequent colds, infections | ☐ | ☐ | -Chronic Fatigue syndrome | ☐ | ☐ |
| **Menstrual** | | | -Alopecia (female hair loss) | ☐ | ☐ |
| Painful periods | ☐ | ☐ | -Female hair growth on face/ chest | ☐ | ☐ |
| Irregular/ absent periods | ☐ | ☐ | -Dental/ periodontal problem | ☐ | ☐ |
| Heavy periods/ excessive bleeding | ☐ | ☐ | -Dizziness, low blood pressure | ☐ | ☐ |
| Premenstrual syndrome (PMS) | ☐ | ☐ | | | |
| Endometriosis | ☐ | ☐ | | | |
| **Accident/ injury: (describe)** | ☐ | | **Other not listed:** | ☐ | |

**Surgery: (describe)** ☐

Cindy A. Mimo, MS, Clinical Nutritionist
My Life Nutrition, LLC

**Women's Health**

Do you have regular periods? ☐Y ☐N
Age started: Date of last period:
Concerns?

Are you in ☐peri-menopause or ☐post-menopause?
If so, symptoms/ concerns?

Do you take birth control pills? ☐Y ☐N Do you use bioidentical or synthetic hormones? ☐Y ☐N

**Men's Health**

Do you have prostate issues/ concerns? ☐Y ☐N
Describe:

Do you have erectile concerns? ☐Y ☐N
Describe:

**Treatments, Medications & Supplements**

Are you currently being treated for a medical condition? ☐Y ☐N What condition?
List medications you are taking for this condition?

List any other over the counter or prescription medications you are taking:

Vitamin, mineral or other supplements (including probiotics, herbals, botanicals, bioidentical hormones):

Allergies or sensitivities (food, drugs, seasonal, chemical, other):

Recent immunizations/vaccinations?

When did you last take an oral antibiotic?

**Eating Habits & Food Intake**

How many times per week do you eat out, or bring home take-out food?

Do you eat packaged or frozen foods? ☐Y ☐N How often?

Do you typically eat breakfast? ☐Y ☐N

How many meals do you eat per day?

How many times a day do you snack, and what is a typical snack?

Do you drink alcohol? ☐Y ☐N Type?
How much do you drink per day/ week?

Do you smoke cigarettes or cigars? ☐Y ☐ N
How much?

What are your favorite foods?

Do you have food cravings? ☐Y ☐N When?
Circle foods you typically crave: Sweet Salty Breads/ pastas Chocolate Coffee/ caffeine
Other foods you crave:

Do you frequently feel thirst? ☐Y ☐N

What beverage do you drink most in a given day?

Do you often feel hungry? ☐Y ☐N

Do you eat beyond feeling full? ☐ Y ☐N

Do you eat when you are not hungry? ☐ Y ☐N What and why?

Are there any foods will you <u>NOT</u> eat?

What are the foods you eat most frequently?

1.
2.
3.
4.
5.
6.
7.
8.

| **Indicate all that apply to your current state of being, lifestyle and eating habits** | | | |
|---|---|---|---|
| ☐ | Love to eat | ☐ | Afternoon fatigue |
| ☐ | Eat too much | ☐ | Frequent colds, illness |
| ☐ | Erratic eating patterns | ☐ | Poor focus, memory, attention |
| ☐ | Eat on the run, travel frequently | ☐ | Cold intolerance (often cold, slow to warm up) |
| ☐ | Emotional eating | ☐ | Do not plan meals or menus ahead |
| ☐ | Late night eating | ☐ | Rely on convenience foods |
| ☐ | Fast eater | ☐ | Often eat/ drink for business or social occasions |
| ☐ | Skip meals | ☐ | Confused about what to eat |

| **Lifestyle, Exercise, Sleep** | |
|---|---|
| Describe your typical daily energy level?<br>☐Low ☐Mid ☐High | What is your current stress level?<br>☐Low ☐Mid ☐ High |
| Do you engage in regular physical exercise? ☐Y ☐ N<br>Type? Freq? | What do you think causes you stress? |
| Do you have any physical conditions which limit your ability to exercise? ☐Y ☐N<br>Describe: | What do you do to relieve stress? |
| How many hours do you sleep per night?<br>Do you wake feeling rested? ☐Y ☐N | Do experience any sleep problems (getting to sleep, staying asleep, waking in the morning)? ☐Y ☐N |
| What are your hobbies or interests? | |

| **Additional Comments** |
|---|
| Is there anything else you would like to share? |

**Informed Consent**

- Nutrition and exercise are intended to promote general health and wellness and are not intended to replace physician care or medical intervention. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input, and are not intended to diagnose, treat or cure any disease or ailment.
- You accept all responsibility for reviewing diet, nutrition, lifestyle or exercise suggestions with a licensed medical professional before following said suggestions.
- Any activity or program may have inherent risks which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself. You agree to inquire about any activities with which you are not familiar, and provide any information which may limit your participation in suggested activities.
- Results and changes in your general health and wellness may vary depending on medical conditions, medications, and accuracy in following suggested guidelines.
- As your general health and wellness may change with modifications in diet, nutrition and lifestyle, physician prescribed medications may require modification. It is your responsibility to discuss this with your physician. Never reduce or eliminate physician prescribed medications without the direction of your physician or medical care provider.
- Your personal and health information will remain confidential and will not be shared without your consent.
- You give permission for the information provided on this form and discussed in your nutritional consultation(s) to be shared and discussed with the primary care physician you have listed on this form, at the discretion of the clinical nutritionist and in the interest of your general health and wellness.
- Cindy A. Mimo, MS and My Life Nutrition, LLC reserve the right to refuse services to any individual.

By signing below, you agree to the above terms and conditions for participation in nutritional consultation with Cindy A. Mimo, MS and/ or My Life Nutrition, LLC.

Print Name: _____Signature:_____ Date: _____