Cindy A. Mimo, MS, CCN, CNS, CDN
Nutrition Therapist
860-888-6467

Client Intake Form

Personal Information

Name:			Date:
Birthdate:		Age:	Gender: ☐F ☐M
Height:	Weight:		
Street Address:		City:	Zip code:

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/ Internet
☐Referred by: _____

Your Health & Wellness Goals

Reason for visit?

Please list or attach any recent lab test results such as blood, urine or saliva.

What are your primary health and wellness goals and/ or concerns?

Are there any obstacles or challenges that you believe may make it difficult to achieve your health and wellness goals?

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?

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

Condition	Self	Family	Condition	Self	Family
Cardiovascular			**Muscular, Skeletal, Joints**		
High blood pressure	☐	☐	Joint Pain, stiffness, swelling	☐	☐
Low blood pressure	☐	☐	Frequent muscle cramps	☐	☐
High cholesterol	☐	☐	Arthritis, Rheumatoid	☐	☐
Heart attack or stroke	☐	☐	Arthritis, Osteoarthritis	☐	☐
Arrhythmia	☐	☐	Osteoporosis/Osteopenia	☐	☐
Digestive/ Gastrointestinal			**Endocrine**		
Acid reflux/heart burn/indigestion	☐	☐	Diabetes Mellitus Type 1	☐	☐
Constipation	☐	☐	Diabetes Mellitus Type 2	☐	☐
Diarrhea	☐	☐	Hyperglycemia	☐	☐
Frequent gas, bloating or cramping	☐	☐	Hypoglycemia	☐	☐
Hiatal hernia	☐	☐	Thyroid disorder	☐	☐
Celiac disease	☐	☐	Adrenal disorder	☐	☐
IBD, Crohns or Ulcerative Colitis	☐	☐	**Liver**		
Irritable Bowel Syndrome (IBS)	☐	☐	Hepatitis	☐	☐
Genital/Urinary			Cirrhosis	☐	☐
Frequent yeast infections	☐	☐	Gall stones	☐	☐
Urinary tract infections	☐	☐	**Viral/ Bacteria Infections**		
Urinary incontinence	☐	☐	HIV/AIDS	☐	☐
Kidney stones	☐	☐	Sexually Transmitted Disease	☐	☐
Kidney or bladder 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	☐	☐	Gout	☐	☐
Emphysema	☐	☐	Chronic Fatigue syndrome	☐	☐
Frequent colds, infections	☐	☐	Alopecia (female hair loss)	☐	☐
Menstrual			Female hair growth on face/ chest	☐	☐
Painful periods	☐	☐	Dental/ periodontal problem	☐	☐
Irregular/ absent periods	☐	☐	Sleep disorder	☐	☐
Heavy periods/ excessive bleeding	☐	☐			
Premenstrual syndrome (PMS)	☐	☐			
Endometriosis	☐	☐			
Accident/ injury: (describe)	☐		**Cancer, if so list type(s):**	☐	☐
Surgery: (describe)	☐		**Other not listed:**	☐	

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Women's Health

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

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

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 any prescription or OTC medications you are taking for this condition, include dosage.

List any other OTC or prescription medications you are taking for any reason, include dosage.

List vitamin, mineral or other supplements you are taking, including dosage (e.g., probiotics, herbs):

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?
Check 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 you will NOT eat?

What are the foods you eat most frequently?

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

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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? ☐Low ☐Mid ☐High	What is your current stress level? ☐Low ☐Mid ☐ High
Do you engage in regular physical exercise? ☐Y ☐ N Type? Freq?	What do you think causes you stress?
Do you have any physical conditions which limit your ability to exercise? ☐Y ☐N Describe:	What do you do to relieve stress?
How many hours do you sleep per night? 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?	
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 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 and My Life Nutrition, LLC reserve the right to refuse services to any individual.

Payment is due at the time of service. Please call at least 24 hours in advance to cancel and appointment.
The provision of services, work product, advice and delivery of supplements may be suspended due to lack of payment.

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

Print Name: _____Signature:_____ Date: _____

If client is under age 18, parent/ legal guardian consent is required below:

Parent/ Guardian Name: _____Signature:_____ Date: _____

Cindy A. Mimo, MS, CCN, CNS, CDN/ My Life Nutrition, LLC
PO Box 928, Glastonbury, CT 06033

NUTRITIONAL CONSULTING INFORMED CONSENT AND DISCLAIMER FORM

GOAL: The basic goal of My Life Nutrition is to encourage clients to become knowledgeable about and responsible for their own health, and to help them to reach a personal, optimum level of healthiness through nutrition and supplement related education and counseling. Achieving the goal of optimum health, absent other non-nutritional complicating factors requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. There is no guaranty that you will achieve your goal, but My Life Nutrition will make every effort to work with you on that objective.

I will evaluate your nutritional needs and current dietary habits/consumption and make suggestions regarding dietary changes and, if warranted, the introduction of nutritional supplements to your daily routine. I may use laboratory analysis to help me investigate your nutritional needs**. I am not trained to provide medical diagnoses, and no comment or suggestions should be construed as being a medical diagnosis.** While some of my work and suggestions may focus on your current or past medical conditions, I am only providing nutritional advice and will NOT be providing any medical advice of any kind whatsoever. Since every human being is unique, I cannot guarantee any specific result or outcome from my suggestions. Obviously, to the extent that my advice is not followed or followed in a limited manner, results may vary.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. Consulting with me is not a substitute for being treated by your primary-care provider or other appropriate healthcare practitioner. I am not trained or licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases. If, through our sessions, I am made aware of the existence of certain medical conditions, illnesses, injuries or diseases that may afflict you, I plan to incorporate that knowledge into my suggestions to the best of my ability. Nutritional advice is no substitute for medical care and is only a complement to the care you receive elsewhere.

If you are under the care of another healthcare provider, particularly if you are currently taking prescriptions as a part of such care, it is vitally important that you promptly contact your other healthcare provider(s) and alert them to your use of nutritional supplements. My Life Nutrition cannot be responsible in any way for such communication. Nutritional changes you may choose to undertake and the use of supplements in connection therewith may be a beneficial adjunct to more traditional care, and it may also alter your need for or the required dosage of your medication, so it is important you always keep your physician informed of changes in your nutritional program throughout our consulting relationship. Only your physician can make adjustments to prescription medications.

If you are using medications of any kind, you are required to alert me to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist. If you have any physical or emotional reaction to nutritional therapy, discontinue use immediately and contact me to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy. If during our business relationship you are adding, reducing or in any way changing medicine dosages, it is incumbent upon you to notify My Life Nutrition promptly so that any necessary adjustments can be recommended and made.

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COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need and the dietary changes that may be suggested. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct any imbalance that may result. It is recommended that you stay in contact with me so I can be updated on any changes you're experiencing particularly negative ones. Please suggest to your other healthcare provider(s) to contact me via email or telephone with any questions they may have regarding your nutritional protocol. In addition, I am available for in person or telephone consultations with you and your healthcare provider(s) upon request.

FEES: Nutritional consulting and the costs associated with supplements may not be covered by insurance and all costs are the sole responsibility of the client. My Life Nutrition will not be submitting any reimbursement requests or have any contact with any insurance company for any reason. My Life Nutrition's fee and the cost of supplements may qualify for certain employee Section 125 or related plans. Please check with your employer for details. In any event, it is the expectation of My Life Nutrition that payment will be made by you at the time of any session or prior to the delivery of any supplements, whether in person or through other means.

AGREEMENT: By my/our signature(s) below, I/we confirm that I/we have read and fully understand the above disclaimer, am/are in complete agreement therewith and do freely and without duress sign and consent to all terms, conditions and admonitions contained herein. Moreover, I/we agree to indemnify and hold harmless My Life Nutrition and Cindy A. Mimo from and against any loss or cost of any kind whatsoever relating to my/our execution of this document and the terms contained herein.

CLIENT NAME (PLEASE PRINT) _____

CLIENT SIGNATURE _____ DATE _____

For those signing for the client:
SIGNATURE FOR CLIENT _____ DATE _____

RELATIONSHIP TO CLIENT _____

MY LIFE NUTRITION, LLC

_____ DATE_____
Cindy A. Mimo, MS, CCN, CNS, CDN, Nutrition Therapist

Cindy A. Mimo, MS, CCN, CNS, CDN/ My Life Nutrition, LLC
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Food Journal (3 days)

Name _____

Attached is a food journal to assist me in understanding your eating patterns. Please do not modify you eating behavior and try to be "good" in anticipation of my reading your log. I can be most helpful if you give me accurate details. Include meals, snacks and beverages. Examples of mood/feelings: tired, energetic, lethargic, hungry, satisfied, depressed, brain-fog, crabby, sad, etc. Under eating environment indicate if you are eating alone, with other, sitting at the table, in front of the TV, etc.

Date/ Time	Foods eaten/ Preparation	Mood/ feelings after eating	Mood/ feelings 2hrs after eating	Eating environment
6/14 8am	2 fried eggs, 2 slices of white toast with butter, coffee with cream and sugar	Rushed, hungry	Tired, hungry	Alone, standing at counter