



vitalis

nutrition | yoga | adventures

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Hosted by: Pomegranate Community Midwives
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Please fully complete this form and bring it with you to your appointment

Contact Information

Today's Date: _____
Name: _____
Address: _____ City: _____ Province: _____
Email: _____
Age: _____ Birth date: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Personal Information

Occupation: _____
Do you enjoy your work? _____
How did you hear about Vitalis? _____
Reason for today's visit: _____

What are your goals and expectations for working with a holistic nutritionist?

What are your main health concerns? _____

Have you ever been diagnosed with a condition related to your concern? _____

When was the diagnosis made? _____

Who made the diagnosis? (Medical Doctor, Naturopath, Registered Massage Therapist etc.) _____

If comfortable please provide name and phone number of diagnosing physician:

Have you seen any specialists concerning this? _____

How has this condition been treated until now? _____

Medical history

What forms of treatment/ therapy do you currently use? _____

Medical Doctor name and phone number: _____

Naturopath name and phone number: _____

Physiotherapy: _____

Counselling : _____

Acupuncture: _____

Massage therapy: _____

Chiropractor: _____

Other: _____

Have you ever been hospitalized/ treated for serious conditions or surgeries? _____

What is your blood type? _____

Please indicate which of the following you have experienced

Surgeries: (check)	Trauma: (check)	Vaccinations
Tonsils	Shock	Small pox
Adenoids	Grief	Polio
Intestines/ Colon	Severe Fright	Meningitis
Heart	Nervous Breakdown	Typhoid
Appendix	Period of Stress	Tetanus
Hernia	Overwhelm	Hepatitis
Kidney Stones	Other: _____	Flu
Gall Stones	Describe: _____	Other: _____
Uterus		
Prostate		
Cataract		
Wisdom teeth		
Other: _____		

Please list any additional supplements you are currently taking:

Vitamin or minerals: _____

Herbal remedies: _____

Homeopathy: _____

In the lists below, circle all illnesses that you have experienced and/ or place and X for illnesses experienced by immediate family

Abortion	Appendicitis	Alcoholism	Allergies (food or drug) list:
Allergies (environmental) list:	Autoimmune disease	Anemia	Asthma
Bladder Problems	Back pain/Sciatica	Blood disorder	Candida(yeast syndrome)
Celiac Disease	Cancer (type):	Chronic Fatigue	Chicken Pox
Crohn's Disease	Colitis	Constipation	Clinical Depression
Diabetes	Diverticulitis	Eating Disorder list:	Environmental Illness
Epilepsy	Fainting	Fibroids	Fungus
Fibromyalgia	Food Poisoning	Gall or kidney stones	Gall Bladder Disease
Gestational Diabetes	Gout	Hair loss	Hay Fever
Heart Problems	Hepatitis	Hiatal Hernia	High Blood Pressure
Hysterectomy	Hyperthyroid	Hypothyroid	Hypoglycemia
Irritable Bowel Syndrome	Infertility	Jaundice	Kidney Problems
Lupus	Low Blood Pressure	Liver Disease	Malaria
Mononucleosis	Migraine Headaches	Miscarriage	Meningitis
Multiple Sclerosis	Mental Illness	Osteoporosis	Pregnancy Related Illness
Osteoarthritis	Obesity	Pancreatic Disease	Polio
Platelet Disorders	Prostate Problems	Rheumatoid Arthritis	Sinusitis
Stomach/ Duodenum Ulcers	Silver Mercury Fillings	Sexually transmitted disease	Thyroid disorder/ imbalance
Ulcers	Warts	Whooping Cough	Worms/ Parasites

Please check (✓) if you are currently or have in the past 3 months experienced any of these symptoms

Mood

- Relaxed
- Content
- Sad
- Anxious
- Emotional eating
- Angry or Frustrated
- Impatient
- Poor concentration
- Unable to make decisions
- Harboring a grudge

Structural

- Joint pain
- Joint cracking
- Muscle cramps
- History of broken bones & teeth
- Back pain
- Bodily stiffness
- Osteoporosis
- Tooth decay or bone loss
- Grind teeth
- Root canals

Skin

- Acne
- Fungus
- Hives
- Itching
- Bruise easily
- Oily skin
- Dry skin
- Eczema
- Psoriasis

Nails

- White spots
- Vertical lines
- Horizontal lines
- Clubbed
- Spoon
- Stepped surface
- Square and Wide
- Pale nails
- Yellow nails

Eyes & Ears

- Wear glasses
- Blurred vision
- Cataracts
- Dry eyes
- Burning/ itchy eyes
- Poor night vision
- Ringing in ears
- Frequent ear infections
- History of ear infections as a child
- Other:

Immunity & Internal symptoms

- Frequent illness
- Lip splits/ cold sores
- Frequent use of antibiotics
- Cold hands and feet
- Numbness or tingling
- Aversion to cold or heat
- Fever or chills
- Excessive perspiration
- Spontaneous sweating
- Aches and pains
- Body Odour
- Cellulite

Respiratory

- Chronic cough
- Chronic runny nose
- Chronic sore throat
- Sinus infections
- Nose bleeds
- Asthma
- Coughing up blood
- Mucous build ups
- Shortness of breath

Cardiovascular

- Do you wear a pace maker
- Do you have a heart conditions
- Are you taking anticoagulant medications
- Heart palpitations
- Poor circulation
- Varicose veins
- Low Blood Pressure
- High Blood Pressure
- Dizziness

Female Reproductive

- PMS (describe: _____)
- Cramps
- Excessive bleeding
- Long periods
- Scanty periods
- Pre or post menopausal
- Pregnant
- Ovarian cysts
- Are you planning to have children
- Difficulty with urination
- Do you have annual pap smears
- Low sex drive
- Birth control
- Vaginal discharge
- Menstrual clotting
- Breastfeeding
- C- section
- Hysterectomy
- Endometriosis
- Bladder infections
- Please describe any symptoms that accompany your menstrual cycle:

Male Reproductive

- Low sex drive
- Impotency
- Night urination
- Penal discharge
- Prostate concerns
- Bladder infection
- Difficulty with urination

Digestion

- Poor Appetite
- Bad breath
- Bitter taste in mouth
- Film on tongue
- Bleeding gums
- Eat in hurry
- Vomit easily
- Indigestion
- Heart burn
- Late night eating
- Bloating
- Excessive gas (Belching/ Flatulence)
- Difficulty swallowing
- Nausea

Elimination

- Daily bowel movement
- Loose stools
- Constipation
- Alternation between loose and constipation
- Food in stools
- Blood in stools
- Black Stools
- Hemorrhoids
- Itchy or burning anus
- Rectal fissures
- History of parasite
- Mucous in stools

Diet

Please circle which answer applies to you: Are you a:

- Omnivorous
- Vegetarian
- Vegan
- Raw Foodist

How often do you consume animal products:

Meat: Daily 3-5 days a week Once a week or less

Dairy: Daily 3-5 days a week Once a week or less

Eggs: Daily 3-5 days a week Once a week or less

That are your dietary tendencies?

- Sweet
- Salty
- Rich
- Sour
- Bitter
- Savory
- Warm
- Cold

How many meals a week do you eat out? _____

Where do you grocery shop? _____

Please detail (as accurately as possible) your typical breakfast, lunch, and dinner and snacks:

Time: _____ Breakfast: _____

Time: _____ Lunch: _____

Time: _____ Dinner: _____

Times: _____ Snacks: _____

What is your water source? _____ How much water do you consume per day? _____

How many times per week do you consume the following?

- Pop
- Coffee
- Juice
- Tea
- Herbal Tea
- Alcoholic beverages
- Mineral water
- Soy products
- Milk
- Takeout meals
- Deep fried foods
- Sweets
- Chocolate
- Margarine
- Aspartame
- Other: (please list)

What are the most common ways you prepare your food?

- Baking
- Boiling
- Frying
- Steaming
- Microwaving
- Barbequing
- Raw

Client Consent Form

Vitalis Nutrition offers private consultations, educational workshops and nutritional coaching. The purpose of these services is to help individuals achieve and maintain optimal health and well-being. Vitalis consultants are trained to address individuals in a holistic manner and assessments may include diet, fitness, and/or lifestyle and personal-reflection recommendations for their clients.

Please note that Vitalis consultants do not give medical advice or diagnose.

Consultations/recommendations are intended to compliment the medical treatment offered by a licensed physician. Vitalis advises that you continue to seek medical care of a licensed physician if you are currently under care, and to inform your physician of any information presented by Vitalis consultants.

Statement of Consent

I hereby acknowledge that sessions with Vitalis consultants do not include medical advice or diagnosis and that the information provided from this session (and any subsequent sessions) is educational in nature and intended to support my general well-being. I attest that I am here on my own behalf, to learn and apply nutritional and lifestyle recommendations to my life as I see fit. I accept full responsibility for my decisions and well-being as it relates to information and recommendations provided by Vitalis consultants.

I hereby agree,

Signature of client

Date