zarabird&co

All information on this form is confidential and will only be discussed between the client and the practitioner, unless otherwise requested or specified by the client themselves.

Name:
Birthdate:
Phone:
Email:
Address:

Emergency Contact: name: phone:
relationship:

Occupation:
Marital Status:

Please fill out this form as truthfully as possible- the nature of your responses will go a long way in the progress of our work together.

Why are you coming for nutrition and health counseling? What is it you are hoping to receive, gain or accomplish in this work?

Please list your top 3 health concerns:

How would you assess your personal readiness to examine and make changes in your way of eating, overall health and lifestyle routines?

Please record what you ate in the last day and a half. Please include everything that you consumed including any liquids and the approximate time of day you ate.

Please list any and all sensitivities, intolerances or allergies (food, environmental and otherwise):

Do you experience any of the following: please check all that apply.

Gas	Constipation
Bloating	Burning in the stomach, chest or throat
Abdominal cramps	Feeling of heaviness in body and/or energy
Diarrhea	Foggy brain/mind
Fatigue	Digestive pain in the night
Joint pain	Lethargy
Headaches	Sore throat
Blurry vision	Increased sensitivity to temperatures
Night sweats	Tire easily
Recent weight changes	Constipation
Loose stools	Depression
Swollen or painful joints	Lack of appetite

Are there any changes to your way of eating that you feel would help with your health concerns?

Do you cook?

Are you taking any supplements, herbal or nutritional?:
Please list with quantity:

Are you currently taking any pharmaceutical medications?:
please list:

Please list all major illness, surgeries or hospitalizations you have experienced along with dates:

Is there any family history of: (please circle)

Type 1 diabetes	Depression	Mental illness
Type 2 diabetes	Cancer	Substance addiction
Blood pressure issues		Miscarriage
Heart problems		

Do you smoke tobacco?:
How much per day/per week?:

Do you drink alcohol?:
How many drinks per day or per week?:

Do you drink caffeine?:
How much per day or per week?:

Sleep:

At what time do you typically go to sleep?:

At what time do you typically wake?:

How would you describe the quality of your sleep?:

Do you have difficulty falling asleep?:

Do you wake feeling rested?:

Do you wake in the night?:
If so around what time?:

How would you describe your energy levels throughout the day?:

Digestion
Do you have regular bowel movements?
How many per day?:

How would you describe your stools? Please check all that apply:

Loose	Difficult to pass
Formed	Containing undigested food pieces
Oily	Able to fully evacuate
Soft serve consistency	Not able to fully evacuate

Do you experience any of the following symptoms after meals:

Gas	Constipation
Bloating	Burning in the stomach, chest or throat
Abdominal cramps	Feeling of heaviness in body and/or energy
Diarrhea	Foggy brain/mind
Fatigue	Digestive pain in the night
Joint pain	Lethargy
Headaches	Sore throat

Please describe your physical activity. How many times a week and for how long? :

Do you tend to crave salty or sweet foods? :

Do you make time for self-care? :

If yes, please give a few examples of your practices:

What do you do to relax? :

Do you have a daily/spiritual practice? :

What if anything, do you need more of for your health, happiness and/or well-being? :

Women's Health:

Please complete this section even if you no longer menstruate.

Age of first menstruation? :

How many days is/was your cycle? : (from the first day of bleeding to the next time you bleed)

How many days do you bleed for? :

Are your cycles heavy, medium, or light?

What is the quality and color of your menstrual blood? ie- thick, viscous, bright red, dark red, brown, light red/pink, more mucus containing etc.

To the best of your knowledge, do you ovulate?

Date of last menses? :

Do you experience any of the following symptoms during your cycle?
Please check all that apply:

Cramps	Increased emotionality	Headaches	Depression
Bloating	Back pain	Dizziness	Anxiety
Breast-tenderness	Diarrhea	Water-retention	Weight-gain
Breast-swelling	Constipation	Cyclical lumps in breasts	Fatigue
Irritation	Sugar cravings	Salt cravings	
Cyclical cysts in ovaries			

What if anything made/makes these symptoms worse? :

What if anything made/makes them better? :

To the best of your knowledge, where in your cycle do you experience these symptoms? :

Do you have any other questions or concerns regarding your cycle? :

Have you taken any form of hormone replacement therapy? :

Are you currently, or have you in the past taken any forms of hormonal birth-control? If so, what type and for how long? :

Have you ever been pregnant? :

If so, how many times? :

Do you have children? :
How many? :

Have you ever had a miscarriage or ended a pregnancy? :

Is there any chance you may be pregnant? :

Menopause:

When was your last menstrual cycle?:

What symptoms did you experience during the transition and onset of menopause?:

Informed Consent

I understand that Zara Seligson-Goldman is a Certified Holistic Nutritionist and a Certified Herbalist. She is certified to give recommendations and share information regarding nutrition, herbal medicine, lifestyle and health related issues. She is not a licensed practitioner and in no way claims to prescribe, diagnose, treat, or cure disease.
I (the client) assume full responsibility for any decisions, choices or outcomes that I make or that ensue in response to recommendations discussed in sessions.

Please sign and date: