Nutrition Consult

CLIENT INTAKE FORM

Name_____ **Date** _____

Occupation _____ **Birth** _____ **Height** _____ **Weight** _____

Please list your top three health concerns you would like to address naturally.

1.)_____

2.)_____

3.)_____

Regarding the health concerns listed above, list major symptoms you are experiencing for each:

SYMPTOMS FOR 1.)	SYMPTOMS FOR 2.)	SYMPTOMS FOR 3.)

List the treatments you have tried to improve the health concerns listed above:

TREATMENTS FOR 1.)	TREATMENTS FOR 2.)	TREATMENTS FOR 3.)

Do you use tobacco? _____ **alcohol?** _____ **caffeine?** _____

Although results are often noticed within the first weeks of a program, the body often takes 3 months for the comprehensive improvements. Are you willing to follow a program for this length of time? _____

Are you willing to include the following in your nutritional program:

Change your eating patterns? _____ **Begin a form of exercise?** _____

Add new foods to your diet? _____ **Let go of self limiting habits?** _____

Let go of self limiting thoughts/attitudes? _____ **Read recommended publications?** _____

Plese list all medications and dietary supplements that you take (use back if needed).

_____

_____

_____

_____

Client Info

Name _____ **Date** _____

Address _____

_____

Home Phone _____ **Cell Phone** _____

Do you accept text messages on your cell phone: _____

Email _____

How did you hear about us? _____

May we add you to our weekly email newsletters? ☐ **Yes** ☐ **No**

Informed Consent

I acknowledge that Wendy M. Markgraf, HHP, LMMT and staff members of Inside-Out Bodyworks, LLC (herein referred to as IOB) are not medical doctors and do not portray themselves to be. I fully understand that they do not offer allopathic drugs or any other conventional treatments. In addition, I understand that they do not diagnose or treat any condition, illness or disease nor do they practice medicine in any way. I understand that practice of medicine requires a license in the state of Michigan and that these professionals do not hold such a license and that I must seek attention of a medical doctor for a medical condition illness or disease. **Initial** _____

I fully understand that the therapeutic, services, products and information provided are within the scope of holistic healing that being Body, Mind and Spirit. I realize that IOB does not participate with insurance providers, however some HSA & FSA can be used for massage services. **Initial** _____

I understand that Holistic Health Practitioners counsel on the use of non-invasive, natural alternative and complementary therapies and natural substances such as vitamins, minerals, herbs, etc. and that their goal is to inform me of natural non-invasive alternative and complementary therapies that may possibly assist me in obtaining and maintaining health naturally. I accept that the Holistic Health Practitioner adheres to these standards:

1. **Promote only natural, safe, non-invasive therapy provided through nature.**
2. **Encourage a healthy lifestyle that will enhance the bodys own self healing, self recuperating systems.**
3. **View the individual as a whole person- Mind, Body and Spirit.**
4. **Promotes a healthy lifestyle that includes proper attitude, nutrition, rest, exercise, etc., while uncovering those negative factors in one's life which can disrupt the natural health cycles.**

Initial _____

I fully understand that a healthy or unhealthy condition stems from a complex interaction on physical, emotional, nutritional, environmental and lifestyle factors that must be addressed in order to obtain the best possible outcome. The programs designed by IOB staff are intended to bring about a gradual and remedial effect over time, although IOB clients often report improved well-being and many health benefits in the short term. **Initial** _____

Responsibility and participation:

I agree to clearly explain what symptoms I am experiencing, medications I am taking, diagnosis I have received, surgeries I have had and health challenges I face. I am ready and willing to fully participate in my individualized program. I understanding that I am fully responsible for my own personal health research and that I am engaging in this research in order to enhance my health. I fully agree to inform the IOB staff immediately if thereare any problems or concerns with the program as it has been designed for me.

Initial _____

Informed Consent Con.t

Consult your primary care physician, disclaimer:

I understand fully that, as with over-the-counter medications, natural alternative and complementary therapies and substances may interfere with medicaions prescribed by my primary healthcare physician. I acknowledge that any contradications will be explained to me. If I have any concerns about the recommendations, I will consult my primary care physician prior to following any advice recieved by this office. I clearly state that if I choose not to inform my primary care position prior to consuming any natural alternatice and complementart therapies or substances I am doing so of my own accord and I released this office from any liability in this regard. **Initial** _____

Not scientifically proven or FDA approved/possible side effects:

I understand that many of the natural non-invasive therapies and substances utilized and discussed in this office are well researched and have shown positive health benefits in natural medicine practices throughout the United States; however they are not FDA approved. I also understand that, as with all substances, natural included, there is a possibility of unforeseen side effects and allergic reactionsthat could range from mild to severe. I fully agree to inform the IOB staff immediately if there are any problems or concerns with my program that is designed for me. **Initial** _____

Confirmation Statement:

I the undersigned, have read and understand the services I will be receiving at Inside-Out Bodyworks with ***Wendy M. Markgraf, HHP, LMMT. I know and understand that I am expected to exercise my right to choose the therapies and substances to be utilized in my natural health care plan. I understand that the state of Michigan has not adopted any Herbal education training standards for unlicensed herbal practitioners. I agreed to give Inside-Out Bodyworks complete information on my health conditions, medications, diagnosis, past surgeries, possible allergies, and any other information that may be relevant to my health.

Initial _____

***Wendy M. Markgraf is 1.) Certified Holistic Health Practitioner, 2.) Certified Master Herbalist 3.) Licenced Medical Massage Therapist. License #7501001639. NPI # 1649662859. Certified through Blue Heron Acdemy of the Healing Arts.**

Print Name _____

Client Signature _____ **Date** _____

Witness _____ **Date** _____