Real Functional Healing, LLC
www.realfunctionalhealing.com
miranda@realfunctionalhealing.com
720-315-2386

# Client Intake Form

Name: _____ Date:_____

Phone: _____(Home) _____(Cell) _____(Work)

Email: _____

Address: _____

Gender: _____ DOB: _____ Height: _____ Weight: _____

Ethnicity: _____ Marital Status: _____

Occupation: _____ Average hours worked per week: _____

How long have you been at current job? _____ Do you enjoy your job? _____

Activity level at work (check all that apply):

- ❑ Sitting
- ❑ Driving
- ❑ Standing/walking
- ❑ Mixture of sitting/standing
- ❑ Computer work
- ❑ Heavy lifting
- ❑ Work outside
- ❑ Computer work
- ❑ Other _____

When is your usual bedtime? _____ Rising time? _____

Do you use an alarm to wake up? _____

Do you have trouble falling asleep and/or staying asleep? _____

Please list regular physical activities: _____

_____

Frequency/duration of activities: _____

List hobbies/recreational activities: _____

_____

On a scale of 1-10, how would you rate your stress level? _____

Please list stressors: _____

Have you worked with a nutrition therapist before? ☐/☐

Were you referred by anyone? _____ If so, who?

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**General Medical**

What are your chief complaints (reasons for your visit)?

1) _____

2) _____

3) _____

4) _____

5) _____

How would you describe your health in general? _____

_____

Do you:

Smoke tobacco? _____ How much/often? _____
Drink alcohol? _____How much/often? _____
Use recreational drugs?_____ What kind/how often? _____

How many times have you had dental work in the past five years? _____

Do you have amalgam (silver) fillings? _____ If so, how many? _____

How many times have you taken antibiotics? _____

When were you first prescribed antibiotics? _____

What were they prescribed for? _____

When was the last time you took antibiotics? _____

What were they prescribed for? _____

Are you currently being treated for any medical conditions? Please list: _____

_____

Please describe any past and/or present medical issues:

Autoimmune conditions: _____

Heart or blood vessels: _____

Bones or skeletal: _____

Kidneys or bladder: _____

Genital or reproductive: _____

Lungs or chest: _____

Head, sinus, ears: _____

Abdominal or intestinal:_____

Digestive/Bowel changes: _____

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Brain or neurological: _____

Cancer: _____

Diabetes: _____

Allergies: _____

Arthritis: _____

Hepatitis: _____

HIV/AIDS: _____

Alcoholism/Drug Abuse: _____

Eyes: _____

Skin: _____

Psychological/Emotional: _____

Frequent colds or infections: _____

Other: _____

Were you born vaginally or through C-section? _____

Were you breast fed or bottle/formula fed? _____

Blood type (if known): _____

List all medications currently taken (include frequency/dosages): _____
_____
_____

List all supplements currently taken (include frequency/dosages): _____
_____
_____

Do you have any known food allergies? _____ Please specify: _____
_____
_____

How do they affect you?
_____
_____

Do you have seasonal allergies? _____ Please describe: _____
_____

Primary care physician: _____ Phone: _____

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**Nutrition and Eating Habits:**

How often do you have a bowel movement? _____

Any problems with your bowel movements? Please specify: _____
_____

How often do you experience diarrhea and/or constipation? Provide details: _____
_____

Do you drink coffee? _____ How much per day? _____

Do you drink sodas? _____ How many per day? _____

How much water do you drink per day? _____

List your favorite foods _____

List foods that you absolutely will not eat _____

Religious or Dietary Restrictions _____

Describe an average breakfast: _____
_____

Describe an average lunch: _____
_____

Describe an average dinner: _____
_____

Do you eat snacks? _____ What time(s) of the day?_____

Describe an average snack _____
_____

How would you describe your relationship with food? (Check all that apply):

- ❑ Emotional eater
- ❑ Eat out of boredom
- ❑ Often forget to eat
- ❑ Love to eat
- ❑ Eat only out of necessity
- ❑ No joy in eating
- ❑ Feel hungry all the time
- ❑ Overeat/don't know when to stop eating
- ❑ Healthy eating habits

Are you currently on a diet? _____ If so, please explain: _____
_____

Do you weigh yourself? _____ If so, how often? _____

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What would you like to weigh? _____

Any recent weight loss/gain? _____

What food(s) are you not willing to give up? _____

How often do you dine out? _____

What restaurants do you like? _____

Do you eat fast food? _____ How often? _____

What popular diets have you tried and what were your experiences with them? _____
_____
_____

Where do you usually shop for food? _____

Who does most of the grocery shopping in your family? _____

What is your weekly budget for food? _____

Who does most of the cooking at home? _____ Do you enjoy cooking? _____

How many members in household? _____

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# Office Policies and Fees

Welcome! I look forward to working with you to help achieve your health goals. The following guidelines are in place to help answer your initial questions and facilitate our work together.

## Billing and Insurance Coverage

Payment is due at time of service in the form of credit or debit card. Due to the virtual nature of this practice, I am currently unable to accept cash or personal checks. Food For Thought Nutriton Therapy, LLC does not accept insurance due to Colorado liscensing regulations.

## Cancellation Policy

A designated time slot is reserved for all nutrition appointments, and no shows or last minute cancellations affect both the practitioner and other clients trying to schedule. If less than 24 hours notice is given, the full session fee will be charged. Your cooperation and understanding is appreciated.

## Fee Schedule

**Initial Consultation** (75 minutes):

- $199 (any supplements recommended are not included in this price)

**Meal Plan (1 hour):**

- $150

**Follow Up Sessions** (Length of time needed varies by individual):

- 30 minutes: $75
- 15 minutes: $37.50

*Your signature below confirms that you understand and agree to the office policies and fee schedule outlined above*

_____ _____

Signature Date

*(Parent or legal guardian must sign if patient is below 18 years of age)*

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**Credit Card Payment Form**

Payment is due at time of service in the form of debit or credit card. My payment for nutritional counseling includes reasonable email communication with my nutritionist at no extra charge. Frequent and/or lengthy email communication will necessitate scheduling of a phone appointment that will be billed at the regular rate. My appointment is a reservation of the Nutritionist's time and prevents other clients from reserving that time. Therefore, even if I do not attend the scheduled appointment, I will be charged for that time if a 24 hour notice is not given via email or phone

Card Holder's Name: _____

Credit Card Number: _____

Expiration Date: _____ CVC Code: _____

Cardholder's Billing Address and Zip Code:

_____

_____

By signing below, I agree that I have read, understand, and will adhere to the above policies. I grant permission to Food For Thought Nutrition Therapy, LLC to charge my credit/debit card for any appointment not paid on the day of service and/or for any appointment(s) not cancelled with 24 hours notice.

_____ _____
Signature Date
***(Parent or legal guardian must sign if patient is below 18 years of age)***

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**Client Agreement and Release**

I,_____, understand that nutrition therapy is not intended as a diagnosis, treatment, prescription or cure for any disease, mental or physical, and is not intended as a substitute for regular medical care. In Nutrition Therapy there are no medical procedures performed and medications are not prescribed.

I understand that Miranda Meyer is a Master Nutrition Therapist and has completed two years of school at The Nutrition Therapy Institute. I agree to pay Ms. Meyer's rates that are outlined on the fee schedule attached to this agreement.

I understand that Miranda Meyer, MNT can provide nutritional evaluation, dietary suggestions, supplement protocols, and lifestyle recommendations for the purpose of enhancing health. She can help with understanding the nutritional ramifications of a medical diagnosis and understanding how diet, supplements, and lifestyle may assist the path to recovery and provide supportive care. Ms. Meyer can help with understanding how diet and lifestyle choices can minimize risk of preventable degenerative disorders.

I understand that Miranda Meyer can assess nutritional health and body-system balance with the use of techniques such as *Functional Blood Chemistry Analysis, Saliva Adrenal Stress Index,* and *Stool Analysis.* I understand that these techniques are used in the counseling of nutritional health and are strictly non-diagnostic in nature.

This agreement is being signed voluntarily and not under duress of any kind.

_____ _____

Signature Date

*(Parent or legal guardian must sign if patient is below 18 years of age)*

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Primary Care Doctor: _____

Address: _____

_____

Phone: _____

Other HealthCare Provider:

Name/Specialty:_____

Address: _____

_____

Phone: _____

Signature: _____ Date: _____
*(Parent or legal guardian must sign if patient is below 18 years of age)*