EAT WELL NUTRITION & WELLNESS, INC.
4269 S. 144TH STREET,
OMAHA, NE, 68137
402-740-6655

Thank you for choosing our clinic to help you meet your nutritional health goals. It is our mission to guide, support and respect you as you reach towards better health through education, support and lifestyle management. Baby steps or major steps, it is our honor and privilege to hold your hand through the fulfillment of the changes you choose to make.

The holistic paradigm is a partnership between the client (who is in the drivers seat) and Eat Well Nutrition & Wellness, Inc. as your guide, with self-empowerment as the final outcome. Together we will design a comprehensive plan for you, and provide the necessary support for healing.

To get the most our time together, please have these forms completed and bring them with you to your scheduled visit.

We look forward to being of service to you.

Sincerely,

Kathryn Bratberg, RN, M.S. CNP
Board Certified in Holistic Nutrition®

Date of Appointment: _____
Time of Check- in: _____

Estimated Length of Visit: _____
Estimated Cost of Visit: _____
_____

NOTE: PLEASE BRING ALL OF YOUR SUPPLEMENTS WITH YOU TO THE APPOINTMENT FOR REVIEW.

EAT WELL NUTRITION & WELLNESS, INC.
NUTRITION / HEALTH HISTORY

TODAYS DATE _____ REFERRED BY _____

NAME _____M __ F__ BIRTHDATE ___/___/___ AGE__

OCCUPATION_____

MARITAL STATUS: __Single, __Married, __Divorced, __ Widowed, __Separated

YOUR PRIMARY CARE PHYSICIAN: _____

MEDICATION ALLERGIES:_____

FOOD ALLERGIES/ SENSITIVITIES: Wheat, All Gluten, Dairy, Eggs, Soy, Corn, Tree nuts, Peanuts, Shellfish, Other_____

OTHER CHEMICAL SENSTIVITIES / BOTHERSOME SMELLS: i.e. smoke, perfumes, varnish, solvents, ammonia, paint, gasoline products, bus exhaust, formaldehyde, cosmetics, chlorinated water, mold, mildew, LATEX, rubber, soaps/detergents, fabric softener, new carpet smell, hair spray, new fabric smells, smoke from burning fireplace, odors in beauty salons, insect spray, rubbing alcohol, food odors, asbestos, leaking utility gas, mothballs, weed killers,
Other _____

Do these odors cause eye, ear, nose or throat symptoms	Yes	No
Do these odors cause bronchial or chest symptoms	Yes	No
Do any of these odors cause skin rashes	Yes	No

****

DO YOU HAVE ANY IMPLANTED ELECTRICAL DEVICES (i.e. pacemaker) if yes- where and what type: _____

****

1.Reason for office visit: please rank your current complaints and rate the severity (on a scale of 1-10 with 10 being most severe) _____

_____

List any health problems for which you are currently being treated: _____

_____

2. List: Medications: Prescription and Over the Counter Pills, Creams: _____

_____

List all supplements: _____

_____

3. Smoking: Yes __No __ If yes, how much _____ How long have you smoked _____
Do you frequently breath second hand smoke _____

4. Health Issues: Do you have Diabetes, **Heart disease**, Stroke, High or low blood pressure, High or low cholesterol, **Sinus problems**, Eye problems, Asthma, **Thyroid disease**, Hypoglycemia, Cancer- body site _____, Lung disease, **Liver or gallbladder disease**, Arthritis, Auto-immune disease- what type _____, **Chronic fatigue syndrome,** Fibromyalgia, Low grade fevers, **Headaches,** Panic attacks, Dizziness, **Anxiety,** Depression, Neurological conditions, **Rash,** Skin conditions _____, Osteoporosis, **Peptic ulcer**, Diverticulitis, Gum disease, **Other** _____(circle which)

5.Surgeries:_____

Full body anesthesia _____

Do you have any Pins. Clamps, implants, prosthesis internally _____

6. Accidents/ injuries _____

7. Toxic body exposure: (*circle what applies*) nail polish, fake nails, do you work around toxic chemicals, have you ever had toxic chemical spilled on you?

8. Drugs (this is confidential information) Do you now, or have you ever used recreational drugs:_____

9. Stress - Please rate your current stress level (scale of 1- 10. With 10 being the worst stress) ____
What is the reason for your stress _____

10. Dental Health. Do you have sliver fillings, composites, root canals, bridgework, dentures, veneers, implants, extractions, braces, bleeding gums, sensitive teeth, crowns. (circle which)

11. Have you ever had an eating disorder: anorexia or bulimia _____
Do you consider yourself: __Underweight, __ Normal weight, __Overweight.

12. Have you had any of the following infections: Chicken Pox, Hepatitis, Lyme's disease, Measles, Mumps, Shingles, Tick bites, Pneumonia, TB, Genital Herpes, Fungal infection of hair or nails.

HEALTH OVERVIEW:

1. Sleep (*circle: restful, restless, hard to get to sleep, hard to stay asleep, bad dreams, get up during night*) What time do you go to sleep _____Number of hours sleep per night _____

2. Digestion: How is your digestion: (*circle: adequate, poor, acid reflux, burping, gas, bloating, IBS, pain, nausea, vomiting, ulcers), Other* _____

3. Urination: How are your daily urinations: (*every 2-3 hours, sense of urgency, burning, dribbling, up at night, too small amount, too large amount). Other* _____

4. Bowels: How are your bowel eliminations (*How often: daily, skip days, numerous times a day.* ***Consistency:*** *normal, hard, soft, diarrhea;* ***Color:*** *brown, black, pale or white,*
Other: gas, mucus, foul smell), Hemorrhoids

5. **WOMEN ONLY:** *Pregnant, Breast feeding, regular periods, irregular periods, date of last menstrual period _____, menopause, hysterectomy. Circle symptoms associated with your period: bloating, feeling weak, mood swings, heavy bleeding, back pain, headaches, clots, cramps,).*
Do you take birth control or hormones? If so- what type : _____

6. Exercise: What kind of exercise do you do _____
How often _____ How long at a time_____

7. Electromagnetic exposure: How many hours daily do you spend:
Watching TV _____ Working on a computer____ Talking on phone_____ Cell phone_____
Wearing a pager _____ Wearing a headset ____ Tanning Bed _____ Riding in a car/truck _____
Near electrical equipment- such as copy machines_____, high power lines ___, cell phone tower_____
Transformer _____. During sleep, is your head within 10 feet of a plug in clock? _____.

8. Clothing: How often do you wear 100% natural clothing (cotton, wool, silk, linen) _____
Synthetic clothing (polyester, acrylic, nylon, rayon etc. _____

9. Appliances: Circle - gas stove, electric stove, electric heater, electric blanket, water bed, microwave, Air Purifier(*type)* _____ Water Purifier*(type*) _____

10. Cookware: What type do you use circle: Stainless steel, aluminum, iron, Teflon coated, glass, Pyrex, other _____

11. Shower Filter: What type of bath/ shower filter do you use (for chlorine protection) _____ When did you last change the filter _____

12. Pet: Do you have pets? What kind _____ How many _____ Do they stay in the house _____ On your bed _____ What do you feed them _____

FOOD CHOICES: (*circle each food that you eat often -once a week or more*)

1. Pre-made foods: canned food, boxed cereals, frozen dinners, bottled or frozen juice, take out food
2. Red meat (beef, pork, lamb) commercially raised, naturally raised- organic, grass fed
3. Chicken: commercially raised, naturally raised - organic, grass fed
4. Turkey: commercially grown, naturally raised
5. Fish: canned tuna, fresh fish, frozen fish, farmed fish, wild caught fish, at restaurants
6. Fresh vegetables: commercially grown (store bought) , organically grown (store bought), From natural growers at the farmers market, from the food co-op
7. Fresh fruits: commercially grown(store bought), organic (store bought), From natural growers at the farmers market, From the food co-op.
8. Whole grains: Commercially grown, organically grown
9. Beans: commercially grown, organically grown
10. Eggs, Butter: commercial eggs, organic eggs, commercial butter, organic butter
11. Milk: commercial milk, organic pasteurized milk, organic goats milk, raw dairy
12. Cheese: commercial cheese, organic aged cheese, raw milk cheese
13. Other: commercial ketchup, mustard, spices, vinegar, olive oil

FOOD STRESSORS: (*please indicate how many times a week you consume these*):

1. Stimulants: coffee (Including decaf) ____ Black tea, caffeine drinks ____ Soft drinks _____
   Drinks with Nutrasweet /Splenda_____ Alcohol (beer, wine, other) _____,
   Chocolate _____
2. Toxic Oils: Fried foods _____, Fast food _____, Potato or corn chips _____,
   Roasted nuts _____, Mayonnaise _____, Margarine _____, Peanut butter _____
3. Commercial Dairy: Cows milk _____, Yogurt _____, Ice cream _____
   Cottage Cheese _____,
4. Highly Processed Foods- store bought: Bread _____, Crackers _____, Bagels _____,
Pastries, _____, Pasta _____, Muffins _____, Cookies _____, Candy_____

DO YOU CRAVE SUGAR, SALT, BOTH, NEITHER?

FOOD HABITS:

Eating out: Do you eat at restaurants_____, How many times a week _____
What type of food do you eat there _____

Home made: Do you prepare food at home _____, If so, how often _____
If so, what type of food do your prepare _____

Meal Habits: Do you (*circle one*) Skip meals often, Have irregular eating habits, eat past 7 PM?

MSG: Do you avoid foods that have Natural flavors on the label?

Water: Do you drink tap water: _____, What brand of bottled water do you drink _____
If you have a home water purifier- when was the filter last changed _____

Other toxins: (*circle)* Do you eat foods that have dyes, preservatives, artificial flavors,

Do you eat foods that come from other countries: vegetables, fruits, fish, grains

Do you eat: vegetarian, vegan, restrict fats, restrict salt, restrict carbs, gluten free, any other special diets: _____

TYPICAL DIET: (*Please fill out your typical diet for the last 3 days. Please be detailed. List the type of food(commercial or organic) and the brand. If you say salad- list the vegetables, etc. used. Please Be Honest. This is just a learning experience so you focus on your real diet).*

BREAKFAST (time eaten) _____

_____

_____

_____

LUNCH (time eaten) _____

_____

_____

_____

TYPICAL DIET CONTINUED:
DINNER (time eaten) _____

_____

_____

_____

SNACKS (time eaten) _____

_____

What best describes your overall diet: (*circle all that apply*)
Mostly eat out- fast food, Mostly eat out, but try for healthier options,
Eat whatever is available, Occasional binges, Would never give up meat,
Eat a lot of fresh food (very little from cans or boxes), Mostly homemade meals,
Vegetarian, Vegan, Eat mostly organic, Eat a lot of raw food,
In transition to eating better

Do you want to lose weight _____ If so, how much_____

How important on a scale of 1-10 is your health to you (10 being most important) _____

How much confidence do you have in your bodies ability to heal itself (if given the right nutrients/ supplements) on a scale of 1-10 (with 10 being most confident) _____

How much confidence do you have in medical drugs on a scale of 1-10 (10 being high confidence _____

What are your specific health goals (what do you <u>really</u> want) _____
***Energy and vitality**:
Feel more vital, have more energy, have more endurance, be less tired after lunch, sleep better, be free of pain, get less colds and flu, manage allergies, be less dependent on O.T.C. meds like aspirin, ibuprofen, antihistamines.

***Body composition**:
Lose weight, burn more body fat, be stronger, have better muscle tone, be more flexible,

***Mental and emotional:**
Learn how to reduce stress, improve memory, decrease brain fog, be less moody, feel more motivated

***Life enrichment:**
Reduce my risk of degenerative disease, slow down accelerated aging, Maintain a healthy life longer, Change from treating illness, to creating wellness.

How far are you willing to commit to achieve your goals (please be honest):
____ I **don't think I need to change, see no problems**
____ I don't really want to change much, so will do it later
____ I am willing to make small changes
____ I am willing to change a reasonable amount
____ I will do whatever it takes

How much money to you spend per month on your health, out of pocket $_____

How long do you want to live (check all that apply)

___ age 60 - 60
___ age 70 - 80
___ age 80 - 90
___ age 90 - 100
___ age 100 +

___ as long as I am healthy
___ as long as I have been granted
___ until I complete my mission (purpose) on earth
___ only if my significant other is still alive also
___ forever
___ it is enough already

EAT WELL NUTRITION & WELLNESS, INC
FINANCIAL POLICIES AND PROCEDURES

Thank you for choosing *Eat Well Nutrition & Wellness* for help in effecting change in your life and health. Know that we value your trust in us, and serving your needs is our highest priority.

The purpose of this agreement is to allow us to better serve you and to get the best results in the shortest amount of time, to ensure highest client satisfaction.

APPOINTMENTS:
We ask that you show up 15 minutes prior your appointment, so you may complete your paperwork. Please bring you client history and other paperwork with you, already filled out. Initial appointments are 60 – 90 minutes. We feel it takes that long to cover everything the nutritionist and client desire to cover. We don't want to waste that time with incomplete paperwork.

We require a 24 hour notice for cancellation of appointments. If you need to change your appointment, we will be happy to accommodate you.

Change does not happen overnight. One appointment is not going to effect long-term change. Please consider this as we set up your follow - up appointments. The programs we set up for you will take time and your cooperation to implement.

PAYMENT:
Payment is due for all products and services on the date of service. Acceptable forms of payment are: Visa, MasterCard, Discover, personal check, cash.

INSURANCE:
Eat Well Nutrition & Wellness, Inc. is NOT covered by any insurance carrier, Medicare or Medicaid. As stated above, it is understood and agreed that services rendered are charged to you directly, and payment is expected at the time of service.

ON-LINE SHOPPING WITH METAGENICS:
If you purchase supplements on our website, you are dealing directly with Metagenics, and all payments go directly to them. If there are any problems, however, we will help you to resolve these problems, with Metagenics, to the best of our ability.

I have read over the financial policy and accept these terms. I understand that I am financially responsible for all charges.

_____

Client or Guardian Signature Date