GENERAL INFORMATION

Name: _____ Date: _____

Address: _____

Phone: (Mobile) _____

Email: _____

Date of Birth _____ Age: _____

How did you hear about us?

What are your goals?

What are you struggling with, that may be preventing you from achieving your goals?

AGREEMENT CONCERNING SCOPE OF CARE

Dear Client,

Thank you for your interest in using Nutritional Wisdom LLC to improve your general health through nutrition. You may or may not at the same time be under the care of a physician for primary treatment or for the treatment of a specific medical condition. It is important to understand the scope and extent of the services that Nutritional Wisdom LLC will render in your case. Since a nutritional insufficiency may or may not be associated with a specific condition, or may be the cause of that condition, or may occur as a result of that condition, my concern in your case will be with your nutritional program and your ability to metabolize and utilize the nutrients you consume. If you have a specific condition and desire treatment for that specific condition, you should place yourself under the care of a specialist for such diagnosis and treatment as may be indicated or desired by you. By signing below you acknowledge that in no way are the services rendered by Nutritional Wisdom LLC a substitute for medical attention for a specific condition by a duly licensed physician.

In the nutritional management of your case, Nutritional Wisdom LLC may suggest vitamins, minerals, enzymes, and other nutritional supplements. The purpose of these natural products is limited to:

- Improvement of your overall nutritional status
- Improvement of your metabolism
- Increasing your sense of well-being
- Reducing your pain and discomfort

It is important to understand that you may not receive any of these benefits. Results do not occur predictably in every patient, and in some cases they do not occur at all.

The analysis and advice of Nutritional Wisdom LLC concerning nutrition and the diagnostic evaluation of a condition is not necessarily shared by the American Medical Association, the Food and Drug Association, the American Cancer Society, the Arthritis Foundation, the American Heart Association or similar agencies or organizations. Though significant evidence exists to consider such diagnostics and natural treatments safe and effective, the above agencies or organizations may consider them unproved, investigational or experimental. By signing below you acknowledge that, with full knowledge of these disagreements, you desire to undertake diagnostic evaluation and follow suggestions in your case such as nutritional supplements and natural treatments, which appear to be indicated for your condition under the professional opinion of agents or employees of Nutritional Wisdom LLC.

Sincerely,

Carly Pollack, B.S., M.S. Holistic Nutrition, CCN, Certified Nutrition and Lifestyle Coach,
Founder Nutritional Wisdom LLC

I, _____ , have read this Agreement, fully understand the terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily. I acknowledge that I have received valuable consideration in relation to my execution of this Agreement, which I understand to be a prerequisite to my receipt of Services. Finally, I understand that this Agreement shall be of full force and effect as to any and all Services I receive from Nutritional Wisdom LLC, without regard to the date or timing of such service.

_____ _____

SIGNATURE **DATE**

CANCELLATION AND NO SHOW POLICY

Our goal is to provide the highest quality health and wellness coaching in a timely manner. In order to do so, we need to implement an appointment cancellation policy. This policy enables us to better utilize available appointments for our clients in desire of care.

You will always be confirmed for your appointment time via text, phone or email (please let us know which method is most preferable) within a 48-hour time period. If you need to reschedule or cancel your appointment, **we require that you call a minimum of 24 hours ahead of your appointment time**. This gives another client the opportunity to get off of a waitlist and receive coaching.

We understand that emergencies come up, and for that reason we do not charge for the first late cancel or no show. **After this freebie, we do charge full price for missed appointments, and/or appointments cancelled within the 24-hour time period.**

We thank you in advance for your understanding and cooperation.

I acknowledge Nutritional Wisdom's Cancellation and No Show Policy.

(Sign) _____

(Print) _____

Date _____/_____/_____

METABOLIC TYPING QUESTIONNAIRE

This questionnaire is designed to help you determine the optimal macronutrient ratio (fats, proteins, carbohydrates) to begin the process of fine-tuning your body's feedback mechanisms. For those of you who are not sure what a fat, protein, or carbohydrate is, let us simplify that for you. If the food comes from something that has a set of eyes, it is going to be higher in fats and proteins; fats and proteins most often come together in nature. Foods like vegetables, breads and cereals do not come from a source that has a set of eyes and are generally much higher in carbohydrates and lower in fat and protein. There are a few exceptions to this rule, such as nuts and avocados, which have no eyes, yet are high fat foods.

When answering the questions, circle the answer that best describes the way you feel, not the way you think you should eat! If none of the answers suit you with regard to a particular question, simply don't answer that question. If answer A suits you some of the time (in the morning but not the evening for example), and answer B suits you other times, you may circle both provided that the answers refer to how you may feel on any given day, not within a period of 24 hours.

1. I sleep best:

A. when I eat 1-2 hours before going to sleep

B. when I eat as much as 3 or 4 hours before going to sleep

2. I sleep best if:

A. my dinner is composed of mainly meat with some vegetables or other carbohydrates

B. my dinner is composed mainly of vegetables or other carbohydrates and a comparatively small serving of meat

3. I sleep best and wake up feeling most rested if I:

A. don't eat sweet desserts like cakes, candy or cookies, or if I eat rich dessert that is not overly sweet, such as full fat ice cream

B. even if I should eat a sweet dessert now and then

4. After vigorous exercise, I tend to crave:

A. foods or drinks with higher protein and/or fat content such as a bodybuilder's high-protein shake

B. foods or drinks higher in carbohydrate (sweetener), such as Gatorade, soda, or fruit juice

5. In order to last 4 hours between meals and maintain mental clarity and a sense of well-being, I prefer to eat:

A. a meal predominately meat based, high in protein and fat (such as beef, pork, salmon) with a carbohydrate as a meal supplement

B. a meal predominately carbohydrate based, such as a salad or vegetables with some bread, and a small amount of protein

6. Which best describes your reaction to sugar or sweet foods such as jelly donuts, candy or sweetened drinks:

A. I get a rush of energy, may get the jitters or may feel good for a short time but then I am likely to have a blood sugar crash, resulting in the need for more of the same or having to eat some real food to normalize myself.

B. I do quite well on sweet things and I don't seem to be negatively affected, even though I know that too much is not good for me.

continued on next page...

METABOLIC TYPING QUESTIONNAIRE

7. Which statement best describes your disposition toward food in general:

A. I love food and live to eat!

B. I am not fussed over food in general and I eat to live in general.

8. In general, I prefer:

A. to salt my foods most of the time

B. to taste my foods and apply salt once in a while, but am not particularly attracted to salty foods

9. Instinctually, I prefer to eat:

A. dark meat, such as the chicken or turkey legs and thighs over the white breast meat

B. light meat such as the chicken or turkey breast over the dark leg and thigh meat

10. Which list of fish most appeals to your taste without concern for calories or fat content:

A. anchovy, caviar, herring, mussels, sardines, abalone, clams, crab, crayfish, lobster, mackerel, octopus, oyster, salmon, scallops, shrimp, snail, squid, tune (dark meat)

B. light fish, catfish, cod, flounder, haddock, perch, scrod, sole, trout, tune (white), turbot

11. When eating dairy products, do you feel best after eating:

A. richer, full fat yogurts and cheeses or desserts

B. lighter low fat yogurt and cheeses or desserts

12. With regard to snacking, do you:

A. tend to do better with snacks between meals

B. tend to last between meals easily in general

13. Which characteristics best describe you:

A. creative, digest food well in general, have a strong immune system and don't get sick often, have an appetite for proteins, feel good when eating fats or fatty foods, more muscular or inclined to gain muscle and/or strength easily

B. logical, more lithe of build, tend to be sensitive to temperature changes and flu season and wouldn't really consider your immune system one of your stronger attributes, prefer light meats and lower fat foods, are more inclined toward endurance athletics

Total A answers: _____ **Total B answers:** _____

Scoring on next page...

METABOLIC TYPING QUESTIONNAIRE

To score your test, add the number of questions you circled A and the number you circled B.

- If your number of A answers is three or more than B answers, you are a **Protein Type**
- If your number of A and B answers are tied within two of each other, you are a **Mixed Type**
- If your number of B answers is three more than A answers, you are a **Carb Type**

THE QUICK SYMPTOM QUESTIONNAIRE

from The Diet Cure, Julia Ross, MA

Circle the number next to any symptom that applies to you and calculate your score.

1. Is depleted brain chemistry the problem?

4 Sensitivity to emotional (or physical) pain; cry easily
4 Eat as a reward of for pleasure, comfort, or numbness
4 Worry, anxiety, phobia, or panic
4 Difficulty getting to sleep or staying asleep
3 Difficulty with focus, attention deficits
2 Low energy, drive, and arousal
4 Obsessive thinking or behavior
2 Inability to relax after tension, stress
3 Depression, negativity
4 Low self-esteem, lack of confidence
4 More mood and eating problems in winter or at the end of the day
3 Irritability, anger
4 Use alcohol or drugs to improve mood

Total Score _____

Continued on next page...

THE QUICK SYMPTOM QUESTIONNAIRE

2. Are you suffering because of low-calorie dieting?

4 Increased cravings for and focus on food; overeating

4 Regain weight after dieting, more than was lost

3 Increased moodiness, irritability, anxiety, or depression

3 Less energy and endurance

3 Usually eat less than 2,100 calories a day

3 Skip meals, especially breakfast

3 Eat mostly low-fat carbohydrates (bagels, pasta, frozen yogurt, and others)

2 Constantly think about weight

2 Use aspartame (Nutrisweet) daily

2 Take Prozac of similar serotonin-boosting drugs

2 Have become vegetarian

3 Have decreased self-esteem

4 Have become bulimic or anorectic

Total Score _____

3. Are you struggling with blood sugar instability and stress?

4 Crave a lift from sweets or alcohol, but later experience a drop in energy and mood after ingesting them

3 Dizzy, weak, or headachy, especially if meals are delayed

4 Family history of diabetes, hypoglycemia, or alcoholism

3 Nervous, jittery, irritable on and off throughout the day; calmer after meals

3 Crying spells

3 Mental confusion, decreased memory

3 Hear palpitations, rapid pulse

4 Frequent thirst

3 Night sweats (not menopausal)

5 Sores on legs that take a long time to heal

4 Crave salty foods

4 Often feel stresses, overwhelmed

4 Dark circles under eyes

4 More awake at night

Total Score _____

Continued on next page...

THE QUICK SYMPTOM QUESTIONNAIRE

4. Do you have unrecognized low thyroid function?

4 Low energy

4 Easily chilled (especially hands and feet)

4 Other family members have thyroid problems

4 Can gain weight without overeating; hard to lose excess weight

3 Have to force yourself to do even moderate exercise

4 Find it hard to get going in the morning

3 high cholesterol

3 Low blood pressure

4 Weight gain began near the start of menses, a pregnancy, or menopause

3 Chronic headaches

3 Use food, caffeine, tobacco, and/or other stimulants to get going

Total Score _____

5. Are you addicted to foods you are actually allergic to?

3 Crave milk, ice cream, yogurt, cheese, of doughy foods (pasta, bread, cookies, among others) and eat them frequently

3 Experience bloating after meals

4 Gas, frequent belching

3 Digestive discomfort of any kind

3 Chronic constipation and/or diarrhea

4 Respiratory problems, such as asthma, postnasal drip, congestion

3 Low energy or drowsiness, especially after meals

4 Allergic to milk products or other common foods

3 Under eat or often prefer beverages to solid food

3 Avoid food or throw up food because bloating after eating meals makes you feel fat or tired

4 Can't gain weight

3 Hyperactivity or manic-depression

3 Sever headaches, migraines

4 Food allergies in family

Total Score _____

Continued on next page...

THE QUICK SYMPTOM QUESTIONNAIRE

6. Are your hormones unbalanced?

4 Premenstrual mood swings

4 Premenstrual or menopausal food cravings

4 Irregular periods

3 Experienced a miscarriage, an abortion, or infertility

4 Use (d) birth control pills or other hormone medication

3 Uncomfortable period cramps, lengthy or heavy bleeding, or sore breasts

4 Peri- or postmenopausal discomfort (e.g., hot flashes, sweats, insomnia, or mental dullness)

3 Skin eruptions with period

Total Score _____

7. Do you have yeast overgrowth triggered by antibiotics, cortisone, birth control pills?

4 Often bloated, abdominal distension

3 Foggy-headed

2 Depressed

4 Yeast infections

4 Used antibiotics extensively (at any time in life)

4 Used cortisone or birth control pills for more than one year

4 Have chronic fungus on nails or skin or athlete's foot

3 Recurring sinus or ear infections as an adult or child

3 Achy muscles and joints

3 Chronically fatigued

4 Rashes

3 Stool unusual in color, shape, or consistency

Total Score _____

Continued on next page...

THE QUICK SYMPTOM QUESTIONNAIRE

8. Do you have fatty acid deficiency?

4 Crave chips, cheese, and other rich foods more than, or in addition to, sweets and starches

4 Have ancestry that includes Irish, Scottish, Welsh, Scandinavian, or coastal Native American

3 Alcoholism and depression in the family history

3 High cholesterol, low HDL levels

4 Feel heavy, uncomfortable, and "clogged up" after eating fatty foods

4 History of hepatitis or other liver or gallbladder problems

4 Light-colored stool

4 Pain on right side under your rib cage

Total Score _____

LIFESTYLE ASSESSMENT

Current Weight: _____

Do you consider yourself: Underweight Overweight Just Right

Unintentional weight loss/gain of 10 lbs or more in the last 3 months? Yes No

Recent changes in your ability to: See Hear Taste Smell Feel hot / cold

Check the following statements that apply:

- ☐ Occasionally/frequently skip meals
- ☐ Crave stimulants (coffee, soft drinks)
- ☐ Suffer from fatigue
- ☐ Suffer from chronic pain
- ☐ Currently overweight
- ☐ Suffer from headaches
- ☐ Crave sweets / carbohydrates

Continued on next page...

LIFESTYLE ASSESSMENT

Activity Level – Check your current level or work or lifestyle

- ☐ Level 1 – Very light work: sitting, standing, driving, reading, computer, desk job
- ☐ Level 2 – Light work: light housework, labor, childcare, mechanic, some sitting
- ☐ Level 3 – Moderate work: heavy gardening, housework, labor, no sitting
- ☐ Level 4 – Heavy work: heavy manual labor, construction, digging

Exercise Level – Check your current level of exercise

- ☐ None
- ☐ Level A – Light Exercise: 1-3 times per week, easy pace, stretching, walking
- ☐ Level B – Moderate Exercise: 2-3 times per week, moderate pace, some weights
- ☐ Level C – Heavy Exercise: 3-4 times per week, vigorous pace, weights, fast running

Exercise Frequency and Schedule – *Check which apply*

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 min or more duration per workout
- ☐ 30-45 min duration per workout
- ☐ Less than 30 min duration per workout
- ☐ Use of personal trainer
- ☐ Member of gym
- ☐ Own exercise equipment
- ☐ Walk: # of days/week _____
- ☐ Run, jog, spin, aerobic: # of days/week _____
- ☐ Weight lift: # of days/week _____
- ☐ Stretch: # of days/week _____
- ☐ Yoga: #of days/week _____
- ☐ Other: _____ # of days/week _____

Continued on next page...

LIFESTYLE ASSESSMENT

Balanced Eating – Check which apply

- ☐ Mixed food diet (animal & vegetable)
- ☐ Vegan
- ☐ Specific food restrictions of:
- ☐ Gluten/wheat
- ☐ Dairy
- ☐ Soy
- ☐ Corn
- ☐ Other _____
- ☐ Vegetarian
- ☐ Paleo Diet
- ☐ Fat
- ☐ Salt
- ☐ Eggs
- ☐ Starch/carbohydrate
- ☐ General calorie restriction

Servings per day:

Fruits _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Beef, poultry, fish _____

Eating Frequency – *Check which apply*

- ☐ Skip breakfast or other meals
- ☐ Three meals/day
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Generally eat on the run
- ☐ Graze: small frequent meals (how many/day?) _____

Continued on next page...

LIFESTYLE ASSESSMENT

Stimulants – *Check which apply*

☐ Tobacco

Cigarettes: number/day _____

Cigars: number/day _____

Pipe: number/day _____

Other: _____ number/day _____

☐ Alcohol

Wine: number glasses/day or week _____

Liquor: number of ounces/day or week _____

Beer: number of glasses/day or week _____

☐ Caffeine

Coffee: number of 6 oz cups/day _____

Tea: number of 6 oz cups/day _____

Soda with caffeine: number of cans/day _____

Soda without caffeine: number of cans/day _____

Other: _____ number/day _____

☐ Water

Number of glasses/day _____

Stress Habits – *Check which apply*

Circle the level of stress you are experiencing on a scale of 1 – 10 (1 being the lowest)

1 2 3 4 5 6 7 8 9 10

Continued on next page...

LIFESTYLE ASSESSMENT

Stress Habits – *Check which apply*

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents? Yes No

Do you suffer from insomnia/sleep disorders? Yes No

Do you often abruptly awake from sleep? Yes No

Do you suffer from depression/mood swings? Yes No

Supplement Use – *Check which apply*

- ☐ Multivitamin/mineral
- ☐ EPA/DHA (fish oil)
- ☐ Magnesium
- ☐ Friendly flora
- ☐ CoQ10
- ☐ Herbs - extracts
- ☐ Homeopathy
- ☐ Super foods (bee pollen)
- ☐ Vitamin C
- ☐ GLA (evening primrose)
- ☐ Zinc
- ☐ Digestive enzymes
- ☐ Herbs – teas
- ☐ Chinese herbs
- ☐ Bach flowers
- ☐ Antioxidants
- ☐ Vitamin E
- ☐ Calcium
- ☐ Minerals
- ☐ Amino acids
- ☐ Ayurvedic herbs
- ☐ Liquid Meals (Ensure)

Energy / Vitality – *Check all that apply*

I'd like to:

- ☐ Have more energy
- ☐ Have longer endurance
- ☐ Have more motivation
- ☐ Be less tired after lunch
- ☐ Regain vitality and vigor of my younger years
- ☐ Not use so many over the counter drugs
- ☐ Be free of pain
- ☐ Stop using laxatives
- ☐ Get rid of allergies
- ☐ Sleep better
- ☐ Feel more vital
- ☐ Get less colds and flus

Continued on next page...

LIFESTYLE ASSESSMENT

Longevity / Life Enrichment – *Check which apply*

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Be more at peace
- ☐ Change from treating illness to creating a wellness lifestyle
- ☐ Deepen or begin my spiritual practice
- ☐ Maintain a healthier life longer

Body Composition / Fat / Muscle – *Check which apply*

- ☐ Increase strength
- ☐ Increase muscle
- ☐ Increase flexibility
- ☐ Tone up
- ☐ Decrease body fat
- ☐ Lose weight

Stress Reduction – *Check all that apply*

I'd like to:

- ☐ Be happier
- ☐ Be less moody
- ☐ Be more focused
- ☐ Improve my memory
- ☐ Learn how to meditate
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Increase my mental acuity
- ☐ Learn how to reduce stress
- ☐ Solidify a self care routine

Symptom Assessment on next page...

SYMPTOM ASSESSMENT

Rate each of the following symptoms based upon your typical health for the past 30 days.

0 – Never (0 days per month)

1 – Sometimes (1-5 days per month)

2 – Occasionally (5-7 days per month)

3 – Frequently (7-10 days per month)

4 – Often (10+ days per month)

DIGESTIVE TRACT

__ Nausea or vomiting

__ Diarrhea

__ Constipation

__ Bloated feeling

__ Belching, or passing gas

__ Heartburn

TOTAL: _____

EARS

__ Itchy ears

__ Earaches, ear infections

__ Drainage from ear

__ Ringing in ears, hearing loss

TOTAL: _____

EMOTIONS

__ Mood swings

__ Anxiety, fear or nervousness

__Anger, irritability, or aggressiveness

__ Depression

TOTAL: _____

ENERGY/ACTIVITY

__ Fatigue, sluggishness

__ Apathy, lethargy

__ Hyperactivity

__ Restlessness

TOTAL: _____

EYES

__ Watery or itchy eyes

__ Swollen, reddened or sticky eyelids

__Bags or dark circles under eyes

__ Blurred or tunnel vision *(does not include near or far-sightedness)*

TOTAL: _____

HEAD

__ Headaches

__ Faintness

__ Dizziness

__ Insomnia

TOTAL: _____

Continued on next page...

SYMPTOM ASSESSMENT

HEART

__ Irregular or skipped heartbeat

__ Rapid or pounding heartbeat

__ Chest pain

TOTAL: _____

JOINTS/MUSCLES

__ Arthritis

__ Stiffness or limitation of movement

__ Pain or aches in muscles

__ Feeling of weakness or tiredness

TOTAL: _____

LUNGS

__ Chest congestion

__ Asthma, bronchitis

__ Shortness of breath

__ Difficulty breathing

TOTAL: _____

MIND

__ Poor memory

__ Confusion, poor comprehension

__ Poor concentration

__ Poor physical coordination

__ Difficulty making decisions

__ Stuttering or stammering

__ Slurred speech

__ Learning disabilities

TOTAL: _____

MOUTH/THROAT

__ Chronic coughing

__ Gagging, frequent need to clear throat

__ Sore Throat, hoarseness, loss of voice

__ Swollen or discolored tongue, gums, lips

__ Canker sores

TOTAL: _____

NOSE

__ Stuffy nose

__ Sinus problems

__ Hay fever

__ Sneezing attacks

__ Excessive mucus formation

TOTAL: _____

Continued on next page...

SYMPTOM ASSESSMENT

SKIN

__ Acne

__ Hives, rashes, or dry skin

__ Hair loss

__ Flushing or hot flashes

__ Excessive sweating

TOTAL: _____

WEIGHT

__ Binge eating/drinking

__ Craving certain foods

__ Excessive weight

__ Compulsive eating

__ Water retention

__ Underweight

TOTAL: _____

OTHER

__ Frequent illness

__ Frequent or urgent urination

__ Genital itch or discharge

TOTAL: _____

GRAND TOTAL: _____

VITALITY SURVEY

Rate each of the following symptoms based upon your typical health for the past 30 days.

0 – Never (0 days per month)

1 – Sometimes (1-5 days per month)

2 – Occasionally (5-7 days per month)

3 – Frequently (7-10 days per month)

4 – Often (10+ days per month)

__ Experience indifference (don't care)?

__ Lose your sense of humor/take life too seriously?

__ Experience doubt or indecision?

__ Experience worry and anxiety?

__ Feel over cautious or pessimistic?

__ Lack self confidence or feel low self esteem?

__ Experience stress or feel nervous or tense?

__ Feel irritable or oversensitive?

__ Experience difficulty concentrating and loss of clear thought?

__ Experience inadequate energy (fatigue)?

Continued on next page...

VITALITY SURVEY

__ Have coffee, tea, tobacco, sugar or other stimulants as a pick up?

__ Experience nervous indigestion?

__ Experience loss of sex drive?

__ Experience difficulty sleeping?

__ Experience difficulty getting up in the morning?

__ Feel run down?

__ Feel depressed?

__ Feel like crying for no reason?

__ Find it difficult to sit quietly (without fidgeting, talking, TV, etc.)?

__ Find it difficult to express your feelings?

__ Fear criticism?

__ Fear loss of love?

__ Fear old age or death?

__ Feel "something is the matter with me" but don't know what?

__ Think you might be going crazy (losing it)?

__ Experience rapid heart beat or panic?

__ Feel moody?

__ Feel suicidal or wonder whether life is worth living?

__ Have anxiety about not having enough money?

__ Fear ill health?

TOTAL SCORE: _____

What Your Score Means:

0 – 30 = Powerful Nerve Force : HIGH VITALITY

31 – 40 = Strong Nerve Force : GOOD VITALITY

41 – 50 = Moderate Nerve Force : AVERAGE VITALITY

51 – 60 = Low Nerve Force : LOW VITALITY

61 – 70 = Nervous Fatigue : NERVOUS FATIGUE

71 – 80 = Nervous Depletion : NERVOUS EXHAUSTION

81 – 90 = Serious Nervous Exhaustion : SEVERE BURNOUT

Please bring these completed forms to your first consultation.

If you have any questions, email us at hello@nutritionalwisdom.com or call: (512) 243-7473