



MEMORANDUM

Date: \_\_\_\_\_

To: Patty Middlebrooks, Nutritional Consultant

To establish and clarify my purpose in coming to see you for a consultation, I want to clearly state that my interest is in learning how to establish a good nutritional program and to learn about new life style habits. I understand that this is my personal decision as to whether or not to follow the program that you suggest.

I completely understand that you are not a medical doctor and that this program does not replace the advise of a physician. I understand that your advice is not meant to conflict with the recommendations of doctors or practitioners who are licensed by state or federal laws. I understand that I have the right to choose alternative methods of health treatment for myself and in doing so, accept full responsibility for my actions.

I understand that you do not diagnose disease; that you do not treat disease; that you do not make recommendations that will treat a disease that I have already been diagnosed with.

I fully understand that you recommend that I visit a licensed physician if I have a serious health problem and that I should consult this physician before I make any changes in my diet.

I agree to give you 24-hour notice if for any reason I need to change or cancel an appointment. If I am unable to give this notice, I am fully aware that I will be charged an office fee.

Respectfully Yours,

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I am legal guardian to a minor and accept responsibility for this consultation. My signature acknowledges that I have read all of the above information.

Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Minor's Name: \_\_\_\_\_



# Health and Wellness Coaching @ Pura Derma

## Personal Health Evaluation

### Personal Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Diet, Nutrition and Health Practice

How often do you consume the following? (1 = very frequently, 2 = Often, 3 = rarely, 4 = never)

Refined Sugar	1	2	3	4	Dairy Products	1	2	3	4	Fresh Fruits	1	2	3	4
White Flour	1	2	3	4	Pork/Shellfish	1	2	3	4	Vegetables	1	2	3	4
Alcohol	1	2	3	4	Red Meat	1	2	3	4	Green Salads	1	2	3	4
Fried Foods	1	2	3	4	Chicken/Turkey	1	2	3	4	Whole Grains	1	2	3	4
Caffeine Drinks	1	2	3	4	Artificial Sweeteners	1	2	3	4	Fresh Fish	1	2	3	4

How much water do you drink each day? \_\_\_\_\_ ounces

What kind of water do you drink?

How much sleep do you get each night? \_\_\_\_\_ hours

How do you sleep?

What is energy level like?

How many meals do you eat each day?

How often do your bowels eliminate?

Do you feel like you are under stress? \_\_\_\_ Yes \_\_\_\_ No If so, explain.

Please list all the nutritional supplements are you currently taking?

## Medical Information

What are your health concerns?

List any serious illnesses or surgeries you have had in the past year.

Are you under a medical doctor's care for your condition?  Yes  No  
If so, what medications, drugs or therapies are you currently using?

What medications, medical procedures, supplements or therapies have you previously tried for your condition?

Where any of these supplements or therapies helpful for your condition?  Yes  No  
If so, please note which ones were helpful.

Additional comments or helpful information, if any.

## **Interview Notes**

Additional Comments:

Additional Observations:

Recommendations:

**Record of Additional Visits**

Client Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Status of Client Complaints:

New Observations:

Revised Recommendations:

**Date of Visit:** \_\_\_\_\_

Status of Client Complaints:

New Observations:

Revised Recommendations:

