

Client Intake Form

Thank you for purchasing a coaching session!

The information in this form helps us to support you in your consult/s and to help you start to tune into areas you may never had put much thought into as well. Prior to your appointment, please complete this form to the best of your ability.

Don't forget to schedule your appointment if you are ready for that step. The link should be in your confirmation from your consult purchase. :)

* Indicates required question

1. Name *

2. Phone number *

3. Mailing Address *

4. City *

5. State *

6. Zip / Postal Code *

7. Country *

Consult specifics

8. Is this consultation for you? (If not, please submit the client's name and your relation to them; then complete the remainder of this intake form for this client.) *

9. What are your top 3 health concerns? *

Please list your three main focus areas for your health, first will be considered your main focus unless otherwise noted.

10. Age *

11. Gender *

Mark only one oval.

Female

Male

Prefer not to say

12. What is your current marital status? *

Mark only one oval.

- Single
- Married
- Defacto / Partnered
- Separated
- Divorced
- Widow/Widower
- It's complicated

13. What is your current living situation?

Mark only one oval.

- Stable
- About to move
- Recently moved
- It's complicated

14. Do you have any kids at home or who you still support in an ongoing way? Do you care for anyone in your extended family? eg parents, siblings, etc

Please feel free to share anything that seems relevant - if they require special support or health care, or you often focus on them more than your own health, or in general if there's anything related to your kids which impacts on you and/or your health. If you have already covered details previously, you do not need to repeat them here.

15. Any other concerns you have with your current living condition? (please check all that apply)

Tick all that apply.

- Known issues with my water
- Well/bore water
- City water
- Fluoridated water
- Mold exposure in the home
- Limited exposure to sunlight each day
- Recent remodel / exposure due to renovation

16. Please check all that apply to your occupation / employment situation *****

Tick all that apply.

- Work less than 40 hours / week
- Work 40 hours / week
- Work more than 40 hours / week
- Travel for work less than 50% of the time
- Travel for work more than 50% of the time
- Have a low stress job
- Have a high stress job
- Enjoy my job
- Don't enjoy my job
- Don't work
- Disabled - on disability
- Disabled - not on disability

Food and dietary related

In this section we want to get some insight into your food choices

17. I usually use the following oils when I cook (check all that apply) *

Tick all that apply.

I don't cook at home

Butter

Olive

Coconut

Avocado

Vegetable

Canola

Shortening / Lard

Other: _____

18. On average, how many servings of "fresh" food do you eat per day (fruits, vegetables, green foods, etc.)?

19. What are some of your favorite healthy foods?

20. Do you have any food allergies or intolerances?

21. Are you a vegetarian and/or vegan, or have you been in the past? How long for?

Stress and symptom history

Lets understand your family history, childhood, teenage and beyond health and stress history

22. Mother's health history *

Please share your mother's birthplace and year born, number of pregnancies and births she had, and where you are in the birth order. As best as you can, summarize her health history, including pregnancy experience, traumatic events, etc.

23. Father's health history *

Please share your father's birthplace and year born. As best as you can, summarize his health history, including traumatic events, etc.

24. How would you rate your childhood in terms of stress, sickness? *

Were you sick a lot? Lots of stress in your home life?

Mark only one oval.

: (sick a lot, stressed

1

2

3

4

5

:) not sick much, not much stress

25. Childhood health history *

Where were you born? Were there any stressful events happening in your mothers life before or while she was pregnant with you? Did you have any sicknesses you regularly experienced or that stand out in your memories? Did you move a lot? How was school? As best as you can, summarize your health history, including traumatic or stressful events, etc.

26. Teenage health history *

Were there any significant changes as you transitioned into the teenage years? Were there any stressful events happening in your teenage years? Did you have any sicknesses you regularly experienced or that stand out in your memories? As best as you can, summarize your health history, including traumatic or stressful events, etc.

27. Please rate how you felt about your childhood overall *

Think about how confident you were, positive memories dominating over negative, etc

Mark only one oval.

Unhappy, not positive memories

1

2

3

4

5

6

7

8

9

10

Content, happy and positive

28. Early adult health history *

What are the significant events that stand out in your mind? As you gained independence, did you experience any sicknesses or symptoms/conditions get worse from your childhood/teenage years? Are there any other non-health related events that stand out in your memories? As best as you can, summarize your health history, including traumatic or stressful events, etc.

29. Adult health history *

What are the significant events that stand out in your mind? When did significant symptoms start? Did you have any sicknesses from your earlier years start to amplify now, or suddenly appear? Are there any other non-health related events that stand out in your memories? As best as you can, summarize your health history, including traumatic or stressful events, etc.

General health history

30. Please share with us any relevant history about consuming alcohol, drug use, smoking, etc

Please share any relevant details and history. If you have already covered details previously, you do not need to repeat them here.

31. Do you have any regular digestive complaints such as constipation, diarrhea, bloating, reflux?

Please share any relevant details and history. If you have already covered details previously, you do not need to repeat them here.

32. Do you have a history of dental work including root canals, silver fillings/amalgams, etc?

Please share any relevant details and history. If you have already covered details previously, you do not need to repeat them here.

33. Have you in the past, or presently experienced any of the following conditions/events in your past including (but not limited to) heart failure and/or attack, seizures, pacemaker, high cholesterol, surgeries, stroke, Parkinson's or Alzheimers disease, diabetes, organ transplant (etc)?

Please share any relevant details and history including dates or age at the time of events. If you have already covered details previously, you do not need to repeat them here.

34. If you are female, do you have any female-only conditions you have dealt with, or currently deal with? EG endometriosis, PCOS, hormone imbalances etc.

Please share any relevant details and history including dates or age at the time of events. If you have already covered details previously, you do not need to repeat them here.

35. If you are a female, are you pregnant or breastfeeding now, have been pregnant in the past or plan to get pregnant soon?

Please share general information about the ages of children, any difficulties you had with their pregnancies or deliveries and/or after they arrived. If you have gone through pregnancy losses, please share what you feel comfortable with (even if that's just that you had a miscarriage/s or ectopic pregnancy, later pregnancy loss etc). If you have already covered details previously, you do not need to repeat them here.

36. If you are male, do you have any male-only conditions you have dealt with, or currently deal with? EG prostate problems, impotence, erectile dysfunction, bladder irritation, frequent urination, etc.

Please share any relevant details and history. If you have already covered details previously, you do not need to repeat them here.

Sleep status

Tell us about your sleep.

37. Do you get enough sleep? Do you wake feeling rested? Is your sleep restless or interrupted by frequent waking?

Please share any relevant details and history.

38. Overall, how do you rate the quality of your sleep? *

Mark only one oval.

Poor

1

2

3

4

5

6

7

8

9

10

Amazing

39. What are your habits around sleep and device use/healthy sleep habits? *

This includes how you wind down before sleep, waking up in the morning or during the night.

Tick all that apply.

- Watch TV before bed
- Look at my computer before bed
- Look at my tablet and/or phone before sleeping
- I wear blue-blocking glasses with device use (especially at night)
- Have non-device time before sleep
- If I wake, I can go back to sleep quickly
- If I wake, I toss and turn and can't get back to sleep
- If I wake, I look at my phone/device before going back to sleep
- Leave devices alone for some time (eg 30-60 minutes) after waking to start the day
- Immediately start using a device as soon as I wake (ignoring alarms that may be used)

Supplement and protocol history

We want to learn about what you have done in the past and where you are at now with supplements, medications and the Root Cause Protocol...

40. Have you started any of The Root Cause Protocol STARTS? If so, which steps? *

41. Are you currently taking any prescription or over-the-counter medications? (If yes, please list these) *

42. Are you currently taking any dietary supplements? (If yes, please list these) *

43. Have you used, any of the items found in The Root Cause Protocol list of STOPS?
If so, please list which ones

Any of the following - Iron, Vitamin D3, Calcium, Zinc, Molybdenum, "Drugstore" Once-a-Day, Prenatals, synthetic forms of Ascorbic Acid, High Fructose Corn Syrup, Canola Oil, Fluoride, etc

44. Are you currently using any of the items from the previous question? If so,
please list which ones.

Items include: Iron, Vitamin D3, Calcium, Zinc, Molybdenum, "Drugstore" Once-a-Day, Prenatals, synthetic forms of Ascorbic Acid, High Fructose Corn Syrup, Canola Oil, Fluoride, etc.

Final Thoughts?

Is there any extra relevant information or your history that hasn't yet been covered? Any major stresses in your life, events or situations which may help us support you better?
Please list below

45. Extra Relevant Info *

Client Agreement

Thank you for completing this intake form. We are excited to work with you and to help you achieve your health goals! Please read the following statements closely. If anything is unclear, please contact Customer Service.

DISCLAIMER

The Client understands that the role of the Health Coach is not to provide health care, medical or nutrition therapy services; or to diagnose, treat or cure any disease, condition or other physical or mental ailment of the human body. Rather, the Coach is a mentor and guide who has been trained in The Root Cause Protocol to help clients reach their own health goals by helping clients implement positive, sustainable lifestyle changes. The Client understands that the Coach is not acting in the capacity of a doctor, licensed dietitian-nutritionist, psychologist, or other licensed or registered professional, and that any advice given by the Coach is not meant to take the place of advice by these professionals. If the Client is under the care of a healthcare professional or currently uses prescription medications, the Client should discuss any dietary changes or potential dietary supplements use with his or her doctor, and should not discontinue any prescription medications without first consulting his or her doctor. The Client has chosen to work with the Coach and understands that the information received should not be seen as medical or nursing advice and is not meant to take the place of seeing licensed health professionals.

PERSONAL RESPONSIBILITY AND RELEASE OF HEALTH CARE RELATED CLAIMS

The Client acknowledges that the Client takes full responsibility for the Client's life and well-being, as well as the lives and well-being of the Client's family and children (where applicable), and all decisions made during and after this program. The Client expressly assumes the risks of the Program, including the risks of trying new foods or supplements, and the risks inherent in making lifestyle changes. The Client releases the Coach from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law or equity, which the Client ever had, now has or will have in the future against the Coach, arising from the Client's past or future participation in, or otherwise with respect to, the Program, unless arising from the gross negligence of the Coach.

ARBITRATION, CHOICE OF LAW, AND LIMITED REMEDIES

Any dispute, controversy or claim arising out of or relating to this contract, or the breach, termination or invalidity thereof, shall be settled by arbitration in accordance with the UNCITRAL Arbitration Rules as at present in force. The arbitration shall be administered by the Australian Centre for International Commercial Arbitration (ACICA). The appointing authority shall be ACICA. The number of arbitrators shall be [one or three]. The place of arbitration shall be Brisbane, Australia. The language to be used in the arbitral proceedings shall be in English. Such arbitration shall be conducted by a single arbitrator.

The sole remedy that can be awarded to the Client in the event that an award is granted in arbitration is refund of the Session Fee. Without limiting the generality of the foregoing, no award of consequential or other damages, unless specifically set forth herein, may be granted to the Client. This agreement shall be construed according to the laws of the State of Queensland (Australia). In the event that any provision of this Agreement is deemed unenforceable, the remaining portions of the Agreement shall be severed and remain in full force.

CONFIDENTIALITY

The Coach will keep the Client's information private, and will not share the Client's information to any third party unless compelled to by law.

SCHEDULING

We understand that clients have busy schedules and we take pride in not keeping them waiting or keeping them longer than planned. Each session will end 90 minutes after it was scheduled to begin. Please be on time. If the Client needs to reschedule the appointment, the Client must do so 24 hours in advance.

REFUNDS

If the Client has unused session/s, refunds may be issued upon request.

I understand that I am receiving wellness coaching to improve my nutritional health. I agree that I am receiving suggestions to improve my health. It is my choice and responsibility to improve my health. I understand these are only suggestions and I have not received any guarantees regarding these suggestions.

46. Do you understand this client Client Agreement? *

Tick all that apply.

Yes, I understand and agree to these terms

This content is neither created nor endorsed by Google.

Google Forms