HOLISTIC ST. LOUIS

7501 Murdoch Ave.
Shrewsbury, MO 63119
314-647-3999
Holistichealthstl.com

NUTRITIONAL INTAKE FORM

The information you provide will help us work together and help you with right food choices for optimal health.

CONTACT INFORMATION:

Name: _____

Address: _____

City _____ **State** _____ **Zip** _____

Phone: _____

Email: _____

Occupation: _____

Age: _____ **DOB** _____

Primary Care Physician: _____

How did you hear about us? _____

Health Concerns: _____

_____

_____

Has there been a diagnosis, if so explain: _____

_____

_____

_____

_____

Record Medical Procedures/Tests and Results: _____

_____

_____

Family History: _____

_____

_____

Medications/Nutritional Supplements: _____

_____

_____

NUTRITION HISTORY

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

Typical Food Intake

Breakfast:	**Time of Day**	**Food**	**Serving**
Fruits			
Veggies			
Dairy			
Meats			
Fats			
Water			
Tea/Coffee			
Cakes/sweets			

Lunch: **Time of Day** **Food** **Serving**

Fruits _____

Veggies _____

Dairy _____

Meats _____

Fats _____

Water _____

Tea/Coffee _____

Cakes/Sweets _____

Dinner: **Time of Day** **Food** **Serving**

Fruits _____

Veggies _____

Dairy _____

Meats _____

Fats _____

Water _____

Tea/Coffee _____

Cakes/Sweets _____

Do you prepare your meals? _____

Do you consume organic? _____

Have you seen a Holistic Practitioner before? If yes, describe your experience with them:

_____

_____

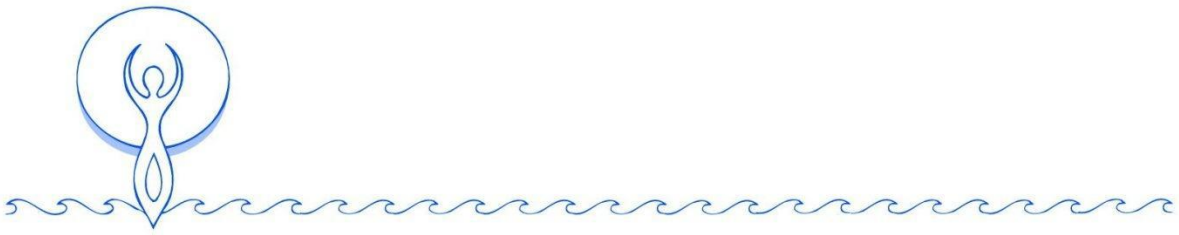
_____

What are your long-term dietary goals?

Additional Comments: _____

Signature: _____ Date: _____

Disclaimer: Please note that the dietary and supplementation suggestions are strictly for nutritional purposes only and are in no way intended to replace ongoing medical therapies. We do not diagnose, offer treatment or prescribe medicine. Also, understand that you are in no way obligated to follow any suggestions given.



HOLISTIC FITNESS

7501 Murdoch Avenue
Shrewsbury, MO 63119
(314) 647-3999
www.holifit.com

HOLISTIC FITNESS
CANCELLATION POLICIES

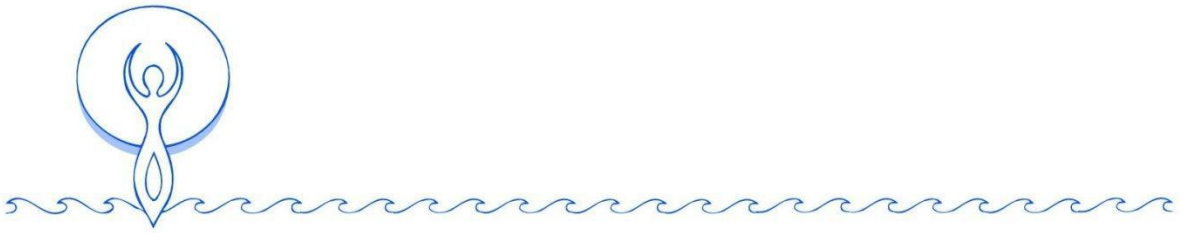
All clients are expected to cancel scheduled appointments at least ***24 hours prior*** to their scheduled appointment times. Clients **cancelling** an appointment **with less than 24 hours notice**, **or those who miss an appointment** without notification, will be **charged a $35 cancellation fee.** If time allows, clients who arrive late for their scheduled appointment will receive a shortened session. Each client is expected to pay fees in full at the time services are provided. Clients will be charged a $25.00 fee for returned checks.

A client who purchases a package of **Private Nutritional Sessions** and subsequently requests a refund on their package will forfeit the discounted rate and unused sessions will revert to the original price. In addition, the client will be required to pay a $25 processing fee. The remaining balance will then be promptly refunded to the client.

All packages expire six months from the date of purchase.
PLEASE NOTE: IN MOST CASES WE WILL PROVIDE YOU WITH AN EMAIL REMINDER OF YOUR SCHEDULED APPOINTMENT. IN THE EVENT YOU DO NOT RECEIVE AN EMAIL REMINDER, YOU ARE STILL RESPONSIBLE FOR YOUR SCHEDULED APPOINTMENT TIME.
By providing my signature below, I understand and agree to all the terms and conditions stated above.

_____

Signature/Date



HOLISTIC FITNESS

7501 Murdoch Avenue
Shrewsbury, MO 63119
(314) 647-3999
www.holifit.com

HOLISTIC FITNESS
CONFIDENTIALITY STATEMENT

We maintain strict client/therapist confidentiality at **Holistic Fitness**. Information discussed in sessions is a private matter. Current law and ethical practice require us to break confidentiality under the following very specific conditions:

1. Law requires that we notify all relevant individuals if it is determined that a client has the intention of doing harm to himself/herself or to another individual.

2. Law requires that we report any current or past suspected incidence of child molestation, abuse, or neglect.

3. In all legal cases, the court can subpoena medical records. A representative from our office may be required to testify or verify information contained within the confines of our office or written records.

If there is ever a necessity to break our confidentiality policy, we will make every attempt to notify you beforehand. If you have any questions regarding this statement, please do not hesitate to ask.
I have read the above material and I understand the confidentiality limitations.

Signature/Date