REFORMED METABOLICS
nourish · connect · hormones

Welcome to Reformed Metabolics! We are so glad you are here. We look forward to working with you on your health concerns.

Each client is individual and special, and each deserves the utmost care. Take time to fill out these forms to the best of your ability. We will go over each question in our first session, "Discovery". If the forms overwhelm you, just fill them out to the best of your ability and we will finish them in Discovery.

Jennifer Woodward, FDN, is not a physician, registered dietitian, or registered nutritionist. She can neither diagnose nor treat. She cannot guarantee outcomes. She is a Functional Diagnostic Nutritionist whose passion is the health and education of women. Please sign below to acknowledge that you agree to the terms of the engagement.

(X)_____ (date)_____

Healing takes time. Dysfunction has been building up in your body for years, possibly decades. Give yourself plenty of time to heal. We ask our clients to commit to at least four months of working together. You will get a personalized health plan which includes diet, rest, exercise, stress relief, and supplementation. We will talk through what all of these things mean for you personally in Discovery.

Each month, you will have access to Reformed Metabolics for support, encouragement, and information. Jennifer works hard to make sure you feel prepared, accountable, and informed each week. Your first Discovery session will last approximately 90-120 minutes.

Standard Package	(x)_____	4 clinic hours + support:	$850
Elite Package	(x) _____	6 clinic hours + labs + support	$3500

YOU ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF WHETHER YOU FINSH YOUR PROGRAM.

I acknowledge the pricing structure: (X)_____

Client Information:

Name_____

Address _____

City _____

State _____

Zip Code _____

Phone (day)_____

Phone (cell) _____

Phone (night) _____

Email _____

Referred by _____

Age _____

Birth Date _____

Gender _____

Height _____

Blood Type _____

Birth Weight (if known) _____

Current Weight _____

Ideal Weight _____

Weight One Year Ago _____

Family/Living Situation: _____

Children: _____

Occupation: _____

Exercise/Recreation: _____

Client History:

1. Have you lived or traveled outside of the United States? If so, when and where?:

2. Have you or your family recently experienced any major life changes? If so, please comment:

3. Have you experienced any major losses in life? If so, please comment:

4. How much time have you had to take o from work or school in the last year?

   - ▫ 0 to 2 days
   - ▫ 3 to 14 days
   - ▫ more than 15 days

Health Concerns

5. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

6. When did you first experience these concerns?

7. How have you dealt with these concerns in the past?

- ▫ doctors
- ▫ self-care

8. Have you experienced any success with these approaches?

9. What other health practitioners are you currently seeing? List name, specialty and phone # below.

10. Please list the date and description of any surgical procedures you have had.

11. How often did you take antibiotics in infancy/childhood?

12. How often have you taken antibiotics as a teen?

13. How often have you taken antibiotics as an adult?

14. List any medicines you are currently taking:

15. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

16. Have any other family members had similar problems (describe)?

17. Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and the symptom:

18. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:

19. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

20. Are there foods that you crave? If so, please explain:

21. Describe your diet at the onset of your health concerns:

22. Do you have any known food allergies or sensitivities?

23. Which of the following foods do you consume regularly?

- ▫ soda
- ▫ diet soda
- ▫ refined sugar
- ▫ alcohol

24. Are you currently on a special diet?

- ▫ autoimmune paleo (AIP)
- ▫ SCD/GAPS
- ▫ dairy restricted or dairy-free
- ▫ vegetarian
- ▫ vegan
- ▫ Other (please describe)

25. What percentage of your meals are home-cooked?

▫ 10 ▫ 20 ▫ 30 ▫ 40 ▫ 50
▫ 60 ▫ 70 ▫ 80 ▫ 90 ▫ 100

26. Is there any special diet you are following at the current time?

27. Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

27. Bowel Movement Frequency

- ▫ 1 time a day
- _ 2 times a day
- _ 3 times a day
- ▫ more than 3 times per day
- ▫ not regularly every day

28. Bowel Movement Consistency

- ▫ soft & well formed
- ▫ often float

- ▫ difficult to pass

- ▫ diarrhea

29. Bowel Movement Color

- ▫ medium brown

- ▫ very dark or black

- ▫ greenish

- ▫ blood is visible

30. Is there anything abnormal about your bowel movement shape, color, consistency, or odor?

31. Do you experience intestinal gas? If so, please explain occasion, duration, and pain level.

32. Have you ever had food poisoning? If yes, please describe in detail, including

1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

32. Please check any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

- ▫ Cancer
- ▫ Heart Disease
- ▫ Hepatitis
- ▫ Venereal Disease
- ▫ Diabetes
- ▫ High Blood Pressure
- ▫ High Cholesterol

- ▫ Allergies
- ▫ Kidney Disease
- ▫ Thyroid Disease

- Depression

- Asthma

- Allergies

- Anemia

- Chronic Yeast Infections

Health Hazards

33. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

34. Do odors affect you?

35. Are you or have you been exposed to second-hand smoke?

36. Do you have mercury amalgam fillings?

Lifestyle History

37. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

38. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

39. How do you handle stress?

Sleep History

40. Are you satisfied with your sleep?

41. Do you stay awake all day without dozing?

42. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

43. Do you fall asleep in less than 30 minutes?

44. Do you sleep between 6 and 8 hours per night?

For Women Only

45. How are/were your menses? Do/did you have PMS? Painful periods: If so, explain.

46. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

47. Have you experienced any yeast infections or urinary tract infections? Are they regular?

48. Have you/do you still take birth control pills: If so, please list length of time and type.

49. Have you had any problems with conception or pregnancy?

50. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Mental Health Status

53. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

53. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

54. At what point in your life did you feel best? Why?

Other

56. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

57. Who in you family or on your health care team will be most supportive of you making dietary change?

58. Please describe any other information you think would be useful in helping to address your health concern(s):

59. What are your health goals and aspirations?

60. Why do you want to achieve that for yourself?

61. How committed are you to changing your lifestyle?

___ completely!-100% __ 80% __60% __ %50 or less- I'm not comfortable with change.

Please complete at least 5 days of the journal.

Name: _____ Date:_____

Food/ Mood/ Poop Journal	Food	Mood	Poop
Morning			
Midmorning			
Lunch			
Midafternoon			
Dinner			
Late Evening			

How many glasses of water did I drink? _____

Bed time:_____ Wake time:_____

How many times awoke during the night?_____

Name: _____ Date:_____

Food/ Mood/ Poop Journal	Food	Mood	Poop
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Midmorning			
Lunch			
Midafternoon			
Dinner			
Late Evening			

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Bed time:_____ Wake time:_____

How many times awoke during the night?_____

Terms of Service Agreement

It is common practice for naturopaths, nutritionists and other non-licensed practitioners to collect your signature on a form such as this. By doing so you acknowledge and accept that we:

- are not medically qualified;
- are not a substitute for advice from a qualified doctor; recommend that you consult your doctor before making any changes to your diet or exercise regime or taking any dietary supplement;
- are not liable for any losses you may suffer by relying on our advice;

are not a covered entity or a business associate of a covered entity under HIPAA.

By your signature below, and/or by instructing us to provide advice and services to you, you indicate your agreement to these terms.

What we do and do not do

We obtain a set of laboratory test results from a [California Certified Laboratory in the United States] and provide you with a nutritional interpretation of those test results that you can use exclusively as an educational tool for personal health purposes.

Your doctor may use the same test results to diagnose and treat disease, but we do not do this. The information we provide is not intended to, cannot, and should not be expected to be a substitute for a personal consultation with your own qualified doctor. We do not accept any liability for any failure to identify any medical condition or disease; this is not the purpose of our services.

We may provide you with information relating to products that we believe might benefit you, but such information is not to be taken as an endorsement or recommendation. Some such products may not be available without a prescription, but we do not dispense or prescribe any prescription products. The information provided is intended for educational purposes only and should not be taken as professional medical advice or used as a substitute for medical care. We are not responsible for any adverse affects or consequences that may result, either directly or indirectly, from that information.

We will make reasonable effort to protect the privacy of your medical information that is shared with us, including any medical test results. However, that information is not protected by doctor-patient confidentiality nor is it governed by HIPAA.

Consult your doctor

We are not qualified medical advisors and make no claims to be so. The information we provide should not be taken to be, and is not a substitute for, personal medical advice and instruction. You should not take any action based solely on our advice.

You should consult your doctor:

for any medical interpretation of your test results;
on any matter relating to your health and well-being;
before making any changes to your exercise or diet;
before taking any nutritional, herbal, homeopathic or hormonal supplementation;
before beginning any therapy.

Exclusion of warranties

We will provide our services to you with reasonable care and skill. But we make no other warranty, express or implied, with respect to those services. All other warranties are excluded to the maximum extent permitted by law.

We make no warranty as to the accuracy of the laboratory test results we receive.

We make no warranty, expressed or implied, as to the quality or effectiveness of any diagnosis, apparatus, treatment or product. In no event will we be liable for any

physical or mental injury, or any negative side effects, that may arise from the use of any such diagnosis, apparatus, treatment or product.

We believe that the information we provide, including that on our web sites, brochures, flyers and information packets, is accurate, but we cannot guarantee such accuracy. We therefore make no warranty as to the accuracy of that information, and it should not be relied upon as being correct, complete or accurate. It is your responsibility to verify such matters independently from primary sources of information and by taking specific professional advice.

Exclusion of liability

If you rely on, buy or use a product or therapy, you do so at your own risk. Each person is different, and the way someone reacts to a product or therapy may be significantly different from another. We cannot predict how you may react to any particular product or therapy.

To the maximum extent permitted by law, we exclude:

• any and all liability in contract, tort (including negligence), breach of statutory duty or otherwise for any direct, indirect, special, incidental, or consequential costs, losses, claims, damages, expenses or proceedings (including but not limited to loss of profits and wasted management time) incurred or suffered by you arising directly or indirectly out of or in connection with our services, including but not limited to any loss, damage or expense arising from any defect, error, imperfection, fault, mistake or inaccuracy with the information or advice we provide;

any and all liability for injury or loss arising out of the use of, or reliance on, the laboratory results and/or the dietary, supplement and lifestyle suggestions we may provide;

• any and all liability for injury or loss arising from any product or treatment you may choose to take;
• any and all liability for any failure to identify any medical condition or disease. You understand and agree

that this is not the purpose of our services.

This is a comprehensive limitation of liability that applies to all damages of any kind, including (without limitation) compensatory, direct, indirect or consequential damages, loss of data, income or profit, loss of or damage to property and claims of third parties.

No recommendation

All material and information we may provide about products and therapies is provided solely for educational purposes and for use when discussing your health with your doctor. By providing you with such material and information, we do not necessarily endorse, recommend or promote any such product or therapy.

•

Signature

I have read and understood the above and I agree to it.

Signature_____

Print Name_____

Date_____

Entering/typing name in the signature field above constitutes signing the document, confirming the signer agrees to the terms and conditions stated.

Thank you! We look forward to working with you!