

Couple's Confidential Health History + Program Agreement

Please print clearly and email the completed form to your Nutritionist prior to your Initial Wellness Consultation.

Names ("His + Hers"): _____

Address: _____

Best email address: _____ How often do you check email? _____

Best Telephone – Cell: _____ Alternate Phone: _____

Are you currently trying to conceive? _____

If no, when would you like to start trying? _____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

[HER | Mama-to-be]

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Number of previous pregnancies? _____ Number of live births: _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns: _____

Other concerns and/or goals? _____

At what point in your life did you feel best? _____

Any serious medical conditions or illnesses/hospitalizations/injuries? _____

How is the health of your mother? _____

How is the health of your father? _____



ALŌ WELLNESS

Justine Campbell, RD, NTP | alowellness.com | info@alowellness.com | (909) 283-4109

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? _____

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

Birth control history: _____

Do you experience yeast infections or urinary tract infections? Please explain: _____

Do you have any digestive issues? Do you experience pain/gas/bloating/heartburn after eating? Constipation/Diarrhea/Gas? Please explain: _____

Allergies or sensitivities? Please explain: _____

Do you take any supplements or medications? Please list: _____

Any healers, helpers or therapies with which you are involved (for example, chiropractic, massage therapy, Naturopath, etc.)? Please list: _____

What role does movement and exercise play in your life? _____

What foods did you eat often as a child?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



What percentage of your food is home cooked? _____ Do you cook? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

What cleaning products do you use in your home currently and in the past? Please list specific brands.

What beauty and skincare products do you use currently as well as in the past? Please list specific brands.

I believe the most important thing I could improve within my diet and lifestyle to improve my conception health is: _____

Anything else you want to share?

[HIM | Dad-to-be]

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns: _____

Other concerns and/or goals? _____

At what point in your life did you feel best? _____

Any serious medical conditions or illnesses/hospitalizations/injuries? _____

How is the health of your mother? _____

How is the health of your father? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? _____

Do you have any digestive issues? Do you experience pain/gas/bloating/heartburn after eating? Constipation/Diarrhea/Gas? Please explain: _____

Allergies or sensitivities? Please explain: _____

Do you take any supplements or medications? Please list: _____

Any healers, helpers or therapies with which you are involved (for example, chiropractic, massage therapy, Naturopath, etc.)? Please list: _____

What role does movement and exercise play in your life? _____

What foods did you eat often as a child?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What percentage of your food is home cooked? _____ Do you cook? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

What skincare products (shampoo, lotion, cologne, etc.) do you use currently as well as in the past? Please list specific brands.

I believe the most important thing I could improve within my diet and lifestyle to improve my conception health is: _____

Anything else you want to share?

Disclaimer & Program Agreement

DISCLAIMER OF HEALTH CARE RELATED SERVICES

Before you choose to use the services of Justine Campbell, RD, NTP, please read the following information FULLY AND CAREFULLY.

GOAL: My basic goal is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimum level. Nutritional Therapy is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A Nutritional Therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. A Nutritional Therapist is not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis. Since every human being is unique, I cannot guarantee any specific result from my programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A Nutritional Therapist is not a substitute for your family physician or other appropriate healthcare provider. A Nutritional Therapist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases.

COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition.

CREDENTIALS & LICENSURE. Registered Dietitians have completed academic and experience requirements established by the Commission on Dietetic Registration, the Academy's credentialing agency, including a minimum of a bachelor's degree from an accredited college or university and an accredited pre-professional experience program. RDs must successfully complete a rigorous professional level exam and must maintain ongoing continuing education to maintain their credential. A Nutritional Therapy Practitioner™ is trained by the Nutritional Therapy Association, Inc.® which provides a certificate of completion to students who have successfully met all course requirements, including a written and practical exam. By my/our signature(s) below, I/we confirm that I/we have read and fully understand the above disclaimer, are in complete agreement thereto and do freely and without duress sign and consent to all terms contained herein.

PERSONAL RESPONSIBILITY AND RELEASE OF HEALTH CARE RELATED CLAIMS

The Clients acknowledge that the Clients 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 Clients expressly assume the risks of the Program, whether or not such risks were created or exacerbated by the Nutritional Therapy Practitioner. The Clients release the Nutritional Therapy Practitioner, his/her heirs, executors, administrators and assigns, its officers, directors, shareholders, employees, teachers, lecturers, agents, and staff (collectively, the Releasees)



from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law, admiralty or equity, which against the Releasees, the Clients ever had, now has or will have in the future against the Releasees, 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 Releasees.

CONFIDENTIALITY

The Clients acknowledge the Nutritional Therapy Practitioner will keep all information exchanged during the program sessions in strict confidentiality. Additionally, the Clients are aware that the Nutritional Therapy Practitioner is prohibited from disclosing protected healthcare information, except upon written authorization by the Clients.

CHOICE OF LAW, ARBITRATION AND LIMITED REMEDIES

This agreement shall be construed according to the laws of the State of California. 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. In the event a dispute arises between the parties, either arising from this Agreement or otherwise pertaining to the relationship between the parties, the parties will submit to binding arbitration before the American Arbitration Association (Commercial Arbitration and Mediation Center for the Americas Mediation and Arbitration Rules). Any judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall be conducted by a single arbitrator. The sole remedy that can be awarded to the Clients in the event that an award is granted in arbitration is refund of the Program 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 Clients.

If the terms of this Agreement are acceptable, please sign the acceptance below. By doing so, the Clients acknowledges that: (1) he/she has received a copy of this letter agreement; (2) he/she has had an opportunity to discuss the contents with the Nutritional Therapy Practitioner and, if desired, to have it reviewed by an attorney; and (3) the client understands, accepts and agrees to abide by the terms hereof.

Justine Campbell, RD, NTP Nutritional Therapy Practitioner	Signature	Date
Client Name	Signature	Date
Client Name	Signature	Date

