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WELLNESS FOR ALL

Nutrition Counseling Intake

Welcome! Thank you for choosing Ripple for your health care needs.
We are here to help and are excited to share our passion for healing.

Thank you for taking the time to fill out these forms. This information gives us a comprehensive picture of your health status and improves our ability to address your health concerns.

Client Information

Name _____

Date of Birth _____ Gender _____

Family/living situation _____

Children _____

Occupation _____

Hobbies/interests outside of work

_____

_____

__

Veteran or active military? Yes No

Cultural Heritage:_____

Were you referred by someone? _____

Health Details (if known)

Height _____ Current Weight _____

Weight one year ago _____

Blood type _____ Blood Pressure _____ Blood Sugar _____

HDL Cholesterol _____ LDL Cholesterol _____

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Family History (please circle all that pertain):

Alcoholism	Gout	Obesity	Alzheimer's
High Blood Pressure	Osteoporosis	Arthritis	Varicose veins
High Cholesterol	Stroke	Cancer	Lupus
Thyroid Disorder	Depression	Menstrual / Fertility Problems	
Type 1 Diabetes	Type 2 Diabetes	Digestive Disorders	

Health Concerns

1. What are your main health concerns? Describe in detail, and if applicable – the severity of symptoms and when they first started.

2. How have you dealt with these concerns in the past? Have you experienced any success with these approaches?

3. What other health practitioners are you currently seeing?

4. List any prescriptions you are currently taking.

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

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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 explain.

3. Please list any surgical procedures you have had.

4. How often did you take antibiotics in infancy/childhood? How often have you taken antibiotics as an adult?

5. Have you been exposed to any chemicals or toxic metals that you know of (lead, mercury, arsenic, aluminum) or mold?

6. Please circle any of the following conditions that apply to you.

Allergies	Chronic Yeast Infections	High Blood Pressure
Anemia	Depression	High Cholesterol
Asthma	Diabetes	Kidney Disease
Anxiety	Heart Disease	Thyroid Disease
Cancer	Hepatitis	Venereal Disease

Digestion/Food

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1. How frequent are your bowel movements?

one a day | twice daily | more | once a week

other _____

2. What is your stool consistency?

Bloody	Hard & dry	Loose or watery	Dark in color
Hard & sinks	Soft & easy	Diarrhea	Light in color
Strong/foul smelling		White or oily looking	

3. Do you have any known food allergies or sensitivities? Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and the symptom.

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

5. Are there any foods that you crave?

6. Circle all that you consume regularly.

soda	diet soda	refined sugar	alcohol	fast food
gluten	dairy (milk, cheese, yogurt)		coffee	

7. Are you currently on a special diet? If so, please describe.

8. How many times per week do you eat out or eat prepared packaged or canned food?

9. Have you had periods of eating junk food, binge eating or dieting?

10. List the 3 **healthiest** foods you eat every week:

11. List the 3 **least healthy** foods you eat every week:

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

Lifestyle

1. How much water do you drink in an average day?

2. How many hours of sleep do you typically get?

3. Do you wake up feeling rested and energized?

4. Rate your typical energy level during the day, with 1 being absolutely exhausted to 10 being bursting with energy. Please note any energy changes throughout the day.

5. Do you currently smoke? Have you been exposed to second-hand smoke?

6. Do you have mercury amalgam fillings?

Movement

1. Does your job require you to be active or sedentary? Please list any details (i.e., frequently bending or lifting).

2. Do you exercise? If so, please list the types of exercise you do and how often.

3. If you answered yes to question 2 - do you enjoy your current exercise regimen? Why do you do it?

Mental Health

1. What are your favorite stress busting activities? How often do you get to do them?

2. Please rate your stress levels in the following areas of your life from 1 – 10, with 1 being no stress to 10 being extremely stressful.
a. Career:
b. Family life:
c. Romantic/Spouse/Partner:
d. Personal feelings towards yourself:

3. How are your moods in general? Do you experience any anxiety, depression or anger?

4. At what point in your life did you feel best? Why do you think that was?

For Women

1. Are you pre-, post-, peri-menopausal or pregnant?

2. How are/were your menses? Do/did you have PMS or painful periods? If so, explain. ☐

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

4. Have you experienced any yeast infections or urinary tract infections? If so, how frequently?

5. Are you using birth control or have you been in the past? If so, please list type and how long you've been using it.

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

Support/Goals

1. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? If not, explain.

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

3. Please describe any other information you think would be useful in helping to address your health concerns:

4. What are your top health goals, aspirations and priorities?

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INFORMED CONSENT FORM & TERMS FOR NUTRITIONAL COUNSELING

I am employing the counseling services of Emily Penn of Ripple so that I can obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my health and wellness.

I understand that Emily Penn is a Holistic Nutritionist and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important complement to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider.

Nutritional evaluation or testing provided in counseling is not intended for the diagnosis of disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals.

I understand that Emily Penn will keep therapy notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me. Records will be stored in a secure location.

Medical records, personal information and history divulged in session to Emily Penn will be kept strictly confidential unless I consent to sharing my medical and nutritional information by way of a signed release.

I acknowledge that I have read and understand the HIPAA privacy agreement.

Nutrition counseling services may be terminated at the discretion of Emily Penn. Client will be notified 30 days in advance of final appointment. This will include a listing of referrals for continuity of care.

Client or Guardian Signature: _____

Date: _____

Thank you for taking the time to fill out these forms.
I am looking forward to meeting you!

Emily Penn, BCHN (Cand.), Holistic Nutritionist

Ripple 2614 E Street Washougal, WA 98671 (360) 207-0134