DISCLAIMER

Your NTC's Name:

*Before beginning Nutritional Therapy with your Nutritional Therapy Consultant ("NTC"), please read the following information **carefully** and then sign and date page 4.*

NUTRITIONAL THERAPY GOALS

The fundamental goal of Nutritional Therapy is to encourage people to become knowledgeable about—and responsible for—their own health. An NTC helps individuals reach their optimal level of overall health by supporting and bringing balance to the five foundations listed below. All five are built upon a single, solid base: a properly prepared, nutrient-dense diet.

- Digestion
- Blood Sugar Regulation
- Fatty Acid Balance
- Mineral Balance
- Hydration

By supporting each of these foundations and helping clients adopt a more nutrient-dense diet, the body's chemistry can be brought back into natural balance, setting the stage for optimal health.

Nutritional Therapy is not designed, however, to treat any specific disease or medical condition. A Nutritional Therapy Consultant is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements, not medical diagnoses or prescriptions. No comment or recommendation from your NTC should be construed as a medical diagnosis or prescription.

Reaching optimal health requires sincere commitment, possible lifestyle changes, and a positive attitude. If you are not willing to change how you eat and live, Nutritional Therapy is not the right approach for you. Since every human being is unique on a biochemical level, we cannot guarantee any specific result from our programs.

HEALTH CONCERNS

If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. An NTC is not a substitute for your family physician or other appropriate healthcare provider. A Nutritional Therapy Consultant is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases or prescribe medications.

If you are under the care of another healthcare provider, it is important that you contact your other healthcare providers and alert them to your use of nutritional supplements. Nutritional

DISCLAIMER

Therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert the NTC to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist. If you have any physical or emotional reaction to Nutritional Therapy, discontinue their use immediately, and contact your NTC to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

COMMUNICATION

Every client is a biochemical individual, and it is not possible to determine in advance how your body will react to the nutrients or supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept targeted nutrients geared to correct imbalances or deficiencies. It is your responsibility to do your part by:

- Following the nutrition guidelines provided by your NTC.
- Eating a properly prepared, nutrient-dense diet.
- Avoiding harmful foods, substances, and behaviors.
- Moving your body daily.
- Getting plenty of sleep, rest, and relaxation.
- Staying in contact with the NTC so they can stay abreast of your progress and provide the best course of action going forward.

If your other healthcare providers have any questions regarding Nutritional Therapy, they are free to contact your NTC.

LICENSURE

Upon completion of the program, passing midterm and final examinations (both written and practical), and completing all required homework, one will be certified as a “Nutritional Therapy Consultant”™ (NTC) by the Nutritional Therapy Association, Inc.®. Note that a Nutritional Therapy Consultant does not diagnose or treat disease, but instead makes nutritional recommendations for balancing the body and promoting optimal wellness. NTCs are approved by the NTA as a certifying organization, but are not licensed or certified by any state. Please check with your state for specific information on licensing requirements.

DISCLAIMER

CLIENT PRIVACY POLICY

During the course of Nutritional Therapy, your NTC will ask that you provide relevant personal details and information relating to your background, health, lifestyle, etc. (hereafter referred to as "Information"), including but not limited to:

- Your full name, physical address, email address, phone number, date of birth, etc.
- Your health history, including injuries, surgeries, prescriptions, etc.

This Information will be gathered from you via in-person interviews, questionnaires, evaluations, intake documents, phone, email, mail, video conferences, etc., and used to:

- Help assess your nutritional needs.
- Make recommendations for dietary changes and nutritional supplements to support your specific nutritional needs and goals.
- Comply with all legal and NTA training obligations.[1]

To ensure the maximum benefit of Nutritional Therapy, it is important that your Information is accurate and up-to-date. If you notice any changes to your health, begin taking new prescriptions, etc., please notify your NTC as soon as possible. It is also your right as a client to access, update, or delete your records at any time. To do so, simply notify your NTC in writing. Your NTC will retain your Information for the length of time you are a client, after which they will take reasonable steps to dispose of your Information in a secure fashion.

Though NTCs are not HIPAA regulated entities, the NTA is committed to protecting client privacy and requires students and graduates to uphold the privacy best practices and the policies laid out in the U.S. *Standards for Privacy of Individually Identifiable Health Information*. Your NTC will take all reasonable steps to protect your Information from unauthorized access, use, or disclosure by using strong passwords, up-to-date software on all devices, and locking file cabinets for physical documents. However, even the best security practices cannot guarantee that all stored data will be completely free from third-party interception or corruption.

In accordance with *Standards for Privacy of Individually Identifiable Health Information*, your consent is required for your NTC to collect, use, and disclose your personal Information. By signing below, you acknowledge consent for your NTC to collect your Information.

[1] If you are working with an NTC student as a practice client, your client folder will be shared with the student's instruction team for grading purposes and returned to you upon completion of the certification program. If you wish to remain anonymous, please instruct the NTC student to use an alias on all client forms.

DISCLAIMER

SIGNATURE

By signing below, I confirm that I have read and fully understand the above disclaimer, am in complete agreement thereto, and do freely and without duress sign and consent to all terms contained herein:

Name:		Date:	
Signature:			

Guardian Name and Signature for Client Under 18 Years of Age:

Name:		Date:	
Signature:		Relationship to Client:	

INITIAL INTERVIEW

Name: Date:

Consultation Time:

To ensure the maximum benefit of Nutritional Therapy, it is important that your information is accurate and up-to-date. If you notice any changes to your health, begin taking new prescriptions, etc., please notify your Nutritional Therapy Practitioner (NTP) or Nutritional Therapy Consultant (NTC) as soon as possible. It is also your right as a client to access, update, or delete your records at any time. Though NTPs and NTCs are not HIPAA regulated entities, the Nutritional Therapy Association, Inc. (NTA) is committed to protecting client privacy and requires students and graduates to uphold the privacy best practices and the policies laid out in the U.S. *Standards for Privacy of Individually Identifiable Health Information*. Please see the *Disclaimer* for further details.

CONTACT INFORMATION

Address 1:

Address 2:

City: State: Zip:

Phone: Type (Cell, Home, Work):

Email:

REFERRED BY

Name:

Email:

BACKGROUND INFORMATION

DOB: Place of Birth: Blood Type:

Age: Gender: Height: Weight:

Occupation: Average Work Hours/Week:

Relationship Status: Number of Children:

HOBBIES & ACTIVITIES

INITIAL INTERVIEW

GOALS & HEALTH CONCERNS

What are your top 3-5 health concerns?

What would you like to gain from Nutritional Therapy? What are your personal health goals?

SLEEP

Do you sleep well? Yes: ☐ No: ☐

Do you wake up during the night? Yes: ☐ No: ☐ If yes, at what time?

What time do you usually go to bed? What time do you usually wake up?

How do you feel when you wake up?

FOOD & DRINK

How much pure water do you drink per day? fl. oz.

Do you drink caffeinated drinks (e.g. coffee, black tea, soda, etc.)? Yes: ☐ No: ☐

If yes, how much per day on average? fl. oz.

What were your eating habits like as a child? (list typical types of food below)

INITIAL INTERVIEW

What % of your food is home cooked? ____ % How many days/week do you typically eat out? ____

What kind of cookware do you usually use (e.g. cast iron, Teflon, aluminum)? ____

What kind of fats do you usually cook with (butter, olive oil, canola, etc.)? ____

In your opinion, what do you think are the three *least healthy* foods you eat each week and why?

Conversely, what do you think are the three *healthiest* foods you eat each week and why?

DIGESTION & APPETITE

Do you often feel tired after meals? Yes: ☐ No: ☐

Do you often feel bloated after meals? Yes: ☐ No: ☐

Do you often feel gassy after meals? Yes: ☐ No: ☐

Do you experience constipation often? Yes: ☐ No: ☐ If yes, how many days/week? ____

Do you experience diarrhea often? Yes: ☐ No: ☐ If yes, how many days/week? ____

Do you often feel excessively hungry? Yes: ☐ No: ☐

Do you often have little or no appetite? Yes: ☐ No: ☐

Do you often crave sugar? Yes: ☐ No: ☐

Do you often crave salt? Yes: ☐ No: ☐

BIRTH & INFANCY

Were you born vaginally or by Cesarean Section? Vaginally: ☐ Cesarean Section: ☐

Were you breastfed as a baby? Yes: ☐ No: ☐ If yes, until what age? ____

INITIAL INTERVIEW

SMOKING & TOXIC EXPOSURE

Do you smoke? Yes: ☐ No: ☐

If so, how many cigarettes per day on average? /day

Are you regularly exposed to secondhand smoke? Yes: ☐ No: ☐

If so, how many days per week on average? /day

Do you have amalgam fillings? Yes: ☐ No: ☐

Have you had amalgam fillings removed or replaced? Yes: ☐ No: ☐

Have you been exposed to toxic substances at work or home? Yes: ☐ No: ☐

If so, what toxins were you exposed to?

MOVEMENT & RELAXATION

Do you enjoy playing sports or being active outside? Yes: ☐ No: ☐

If yes, what are your favorite sports or activities?

On average, how many days a week do you walk? days

On average, how many days a week do you run? days

On average, how many days a week do you do high-intensity interval training? days

On average, how many days a week do you lift weights? days

On average, how many days a week do you do cardio, aerobics, etc.? days

On average, how many days a week do you stretch or do yoga? days

On average, how many hours a day are you sitting? hours

On average, what is your daily screen time (TV, computer, smartphone, etc.)? hours

On average, how many days per week do you meditate? days

On a scale of 1-10 (1 being low and 10 being high), what is your average stress level?

INITIAL INTERVIEW

SUPPLEMENTS, HERBS & MEDICATIONS

Are you currently taking any vitamins, minerals, herbs, homeopathic remedies, prescription or non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Yes: ☐ No: ☐

If yes, please list all of these below including specific product names and dosages/amounts:

Do you have any known allergies to medications or herbs? Yes: ☐ No: ☐

If yes, please list all known allergies below:

MEDICAL HISTORY

Are you currently under a practitioner's care for a specific issue? Yes: ☐ No: ☐

If so, what treatments are you undergoing?

What is your doctor or practitioner's name and contact information?

Name: Licensure:

Address:

City: State: Zip:

Phone: Type (Cell, Home, Work):

Email:

Have you ever been seriously injured, hospitalized, or suffered from a disease? Yes: ☐ No: ☐

INITIAL INTERVIEW

If so, please list all accidents, injuries, diagnoses, surgeries, etc. you have had below, including the date of the event or diagnosis:

FAMILY HEALTH HISTORY

Please check all conditions below that apply to your parents and grandparents:

Diabetes:	☐	Heart Disease:	☐	Stomach/Intestinal Disorders:	☐
Asthma:	☐	Arthritis:	☐	Gallbladder Disease:	☐
Kidney Disease:	☐	Cancer:	☐	Type of Cancer:	

If not listed above, please write in the condition(s) below:

Please list the ages of your parents and grandparents. If a family member is deceased, please write their age of death and cause (if known).

Mother's Age:		Cause of Death (if Deceased)	
Father's Age:		Cause of Death (if Deceased)	
Maternal Grandmother's Age:		Cause of Death (if Deceased)	
Paternal Grandmother's Age:		Cause of Death (if Deceased)	
Maternal Grandfather's Age:		Cause of Death (if Deceased)	
Paternal Grandfather's Age:		Cause of Death (if Deceased)	

INITIAL INTERVIEW

WOMEN ONLY

Do you feel your libido is adequate? Yes: ☐ No: ☐

Are your periods regular? Yes: ☐ No: ☐ Age of your first period: ☐

How frequent are your periods on average? ☐ days

How many days is your flow on average? ☐ days

On average, how heavy is your flow? (Light, Medium, or Heavy) ☐

Do you experience cramps? Yes: ☐ No: ☐ If so, how severe? (Mild, Moderate, or Severe) ☐

Do you experience PMS? Yes: ☐ No: ☐ If so, how severe? (Mild, Moderate, or Severe) ☐

Are you currently pregnant or could you be pregnant? Yes: ☐ No: ☐ If so, how many months? ☐ months

How many children have you delivered? ☐

Were there any birth complications? Yes: ☐ No: ☐ If so, please elaborate below:

Did you receive antibiotics during labor? Yes: ☐ No: ☐

Have you ever had a miscarriage? Yes: ☐ No: ☐ If so, how many? ☐

Have you undergone fertility treatments? Yes: ☐ No: ☐ If so, what kind? ☐

Are you perimenopausal? Yes: ☐ No: ☐ If so, when did changes begin? ☐

Are you menopausal? Yes: ☐ No: ☐ If so, when was your last period? ☐

If you are perimenopausal or menopausal, please list your symptoms below:

INITIAL INTERVIEW

MEN ONLY

Approximate age of onset of puberty: ☐

Number of children: ☐

Do you feel your libido is adequate? Yes: ☐ No: ☐

Do you often wake at night to urinate? Yes: ☐ No: ☐

If yes, how many times per night on average? ☐

Do you have any difficulty or pain with urination? Yes: ☐ No: ☐

Do you have diminished volume or flow? Yes: ☐ No: ☐

Have you lost interest in activities you used to greatly enjoy? (e.g. sports, hobbies, etc.) Yes: ☐ No: ☐

Do you often feel more agitated or irritable than you used to? Yes: ☐ No: ☐

Do you often feel less assertive in daily life than you used to? Yes: ☐ No: ☐

NOTES

FOOD & MOOD JOURNAL

Name _____ Date _____ Wake Time _____ Sleep Time _____

MEAL TIMES	FOODS	DRINKS	SUPPS, HERBS & MEDS	ENERGY & MOOD	MOVEMENT & RELAXATION	DIGESTION & REACTIONS
START: _____ END: _____						
START: _____ END: _____						
START: _____ END: _____						
START: _____ END: _____						
START: _____ END: _____						