Informed Consent Form

and Cancellation Policy

MoodFood Clinic
Aaron Mello, MNT
720-683-8715
aaron@moodfoodclinic.com
www.moodfoodclinic.com

I, _____ am employing the services of Aaron Mello, MNT so I can obtain information and guidance about health factors within my own control as they relate to nutrition, in order to support my health and wellness.

I understand that Aaron Mello is a Master Nutrition Therapist and he does not dispense medical advice or prescribe treatment. He is not a physician, medical doctor or psychologist and does not diagnose, treat, or cure any diseases. Rather, he provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with my eating.

While nutritional support can be an important component of health, I understand that nutritional counseling is not a substitute for appropriate care from by a licensed medical provider.

I understand that Aaron Mello will keep notes as a record of our work together. All such notes, personal information, and medical records will be kept strictly confidential unless I consent to sharing information by way of a signed release.

I understand Aaron Mello, MNT does his best to be punctual and prepared for his appointments and for that reason that his clients must be punctual and prepared also.

Please initial the statements below:

_____I understand I may be charged for my missed appointment if I fail to give at least 24 hours notice to cancel or reschedule an appointment.

_____I understand that if I am more than 15 minutes late for an appointment I may asked to reschedule and I may be charged for the missed appointment.

_____ _____

Client or Guardian's Signature Date

_____

Printed name

Client Intake Form

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You are at the beginning of a journey.

> *"My primary goals are to meet you where you are and to work with you to develop a diet and lifestyle that help you accomplish your health goals, without forcing you to starve yourself or eat foods you don't like."*
> ~Aaron Mello

The basics:

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Email _____

Date of Birth _____ Gender _____ Height _____ Weight _____

Emergency Contact _____ Relationship _____ Phone _____

Occupation_____ Where did you grow up?_____

Why are you here today?

What is the primary reason you're interested in changing your diet and getting healthier?

_____

_____

Are you trying to gain or lose weight? _____ How much weight? _____

How do you feel about coming to see me? _____

_____

How do you feel about your efforts to get healthier—optimistic, frustrated, or somewhere in between?

_____

How important is it to you to lose weight and feel better?

How determined are you to make positive changes to your health? (circle one)

Not at all, really A little bit Pretty determined Yes, whatever it takes!

The first thing I'll ask you to do is complete a 7-day food diary, which will record everything you eat and drink for seven days. Is this something you're willing and able to do? _____

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You'll need tools along your journey.

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Past & Current Medical History:

- Your overall health is strongly related to your weight. Information about other areas of your health will help determine how best to help you achieve your desired weight.
- Circle any conditions you have currently
- Check the boxes of conditions you've had in the past or which run in your family
- Write in any relevant details you wish to include

□ Addiction / alcoholism
□ Anxiety
□ Arthritis
□ Asthma
□ Bipolar disorder
□ Blood clots
□ Blood sugar problems (hypo/hyperglycemia)
□ Breast disease
□ Cancer (type)
□ Celiac disease
□ Chronic fatigue syndrome
□ COPD (emphysema, bronchitis)
□ Depression
□ Diabetes
□ Eating disorder
□ Eczema / skin problems
□ Erectile dysfunction
□ Fibromyalgia
□ Gastrointestinal bleeding
□ Glaucoma
□ Gluten sensitivity
□ Gout
□ Headaches
□ Hearing loss
□ Heart burn / acid reflux
□ Heart disease
□ Hepatitis A, B, or C
□ High blood pressure
□ High cholesterol
□ HIV / AIDS
□ Incontinence
□ Irritable bowel disorder
□ Kidney stones
□ Macular degeneration
□ Osteoporosis
□ Pneumonia
□ Prostate disease
□ Seizures / epilepsy
□ Stomach ulcers
□ Stroke
□ Thyroid disease
□ Urinary tract infections
□ Other (please list) _____
_____

Do you have any allergies to food or medications?

Please list: _____
_____
_____

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You'll need allies to help along the way.

Review of Symptoms:

- Check any conditions that run in your family or you have had in the past
- Circle any you experience currently

Constitutional / Endocrine
- □ Fever
- □ Chills
- □ Weakness / Fatigue
- □ Weight gain / loss (which?)
- □ Insomnia
- □ Snoring
- □ Excessive thirst
- □ Excessive urination
- □ Heat or cold intolerance

Ear, Nose & Throat
- □ Sore throat
- □ Change in voice
- □ Sinus drainage
- □ Nose bleeds
- □ Ear ache / drainage
- □ Hearing loss
- □ Ringing in the ears
- □ Blurred vision
- □ Itchy / dry eyes

Gastrointestinal
- □ Nausea / vomiting
- □ Difficulty swallowing
- □ Hemorrhoids
- □ Diarrhea / Constipation
- □ Black or bloody stools
- □ Abdominal pain
- □ Heartburn / indigestion
- □ Frequent use of laxatives

Urinary
- □ Pain or burning with urination
- □ Difficulty starting or stopping urination
- □ Blood in urine

Genital / Sex Organs
- □ Genital pain / soreness
- □ Painful intercourse
- □ Lack of sexual desire
- □ Problems with performance

Cardiac
- □ Chest pain
- □ Heart palpitation
- □ Irregular heartbeat
- □ Exercise intolerance
- □ Leg swelling

Respiratory
- □ Persistent cough
- □ Coughing up blood
- □ Shortness of breath / Wheezing

Psychological
- □ Depressed mood
- □ Suicidal thoughts / plans
- □ Agitation / irritability
- □ Anxiety
- □ Crying spells

Neurological
- □ Dizziness
- □ Tremors
- □ Balance issues

Medication and Supplements:

List any medications and supplements you take:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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The journey will become your story.

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Lifestyle & Habits

Do you exercise? What kind, how often? _____

_____

What is your temperament? Do you like to be active, climbing mountains, walking leisurely, or sitting on the couch with a book or a laptop?

_____

_____

Are you an early riser or a night owl? _____

How many hours do you sleep per night? _____ Is that consistent? _____

What time of day do you work / go to school? _____

Do you eat food late at night (after 9pm)? _____

How many hours per day do you spend sitting in front of a screen (computer, phone or tablet)?

0-2 hours 2-4 hours 4-8 hours 8 hours or more

How often do you spend time outside? (circle one)

Every day Once or twice a week Once a week at best Never

Drugs, Alcohol and others

Do you smoke cigarettes? How many per day? _____

Do you drink alcohol? How much per week? _____

Do you use any recreational drugs, legal or illegal? What kinds and how often?

_____

_____

Do you have any other kinds of addictions? Do you like to gamble or get an adrenaline rush from racing?

_____

What do you like about how that drug or activity makes you feel?

_____

_____

Are any of these habits and behaviors ones you are interested in changing?

_____

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This form is the beginning of a new chapter.

What do you like to eat?

- Circle the foods that you like and eat often. Scratch out one that you don't like. Write in other foods you like in empty space below these foods.

Beef	Bread	Candy	Cheese	Chinese food	Crackers
Eggs	Fast food	Fish	Fruit	Greek food	Mexican food
Nuts	Pasta	Plain yogurt	Chicken & Turkey	Sauerkraut	Soda
Sushi	Sweets	Tortillas	Raw vegetables	Cooked vegetables	Greasy food

Other:

- What kind of foods do you like? Scratch out ones you don't like.

Bland	Cheesy	Cold	Creamy	Crispy	Crunchy
Decadent	Fresh	Heavy	Hot	Juicy	Light
Meaty	Salty	Savory	Sour	Spicy	Sweet

Eating Preferences & Habits

How often do you eat breakfast? _____

Do you mostly eat alone or with others? _____

How often do you cook? _____ Do you like to cook? _____

Do you enjoy eating? _____

What do you like most about food? _____

_____

What do you like least about food? _____

_____

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How do you want the story to go from here?

Nutrition and Diet

In a typical day, what do you eat?

Breakfast: _____

Lunch: _____

Dinner: _____

Do you eat at consistent times each day? _____

Do you think it matters what you eat? Why? _____

_____

Digestion

How many bowel movements do you usually have per day? _____

Is that fairly consistent or does it vary day-to-day? _____

Have you been diagnosed with Irritable Bowel Syndrome, Leaky Gut Syndrome, or any digestive disorder?

_____

Do you suffer from:

Constipation Diarrhea Both Neither

Do you experience gas, bloating, and/or stomach swelling? When does this happen?

_____

What foods trigger constipation? _____

What foods trigger diarrhea? _____

What foods make you gassy? _____

Thank you for putting the effort into filling out this form!

I certify that everything I've written is true to the best of my knowledge.

Signature _____ Date _____