NUTRITION THE NATURAL WAY
Dani Conway

Health Information

Please fill out this form as accurately as possible. All information is strictly confidential.
Email completed paperwork 48 hours prior to Nutrition & Wellness Jumpstart Session

Personal Overview

Name _____ Date _____

Referred By _____

Address _____ City _____

State _____ Zip _____ Country _____

Preferred Phone _____ 2nd Phone _____

Email _____ Fax _____

Communication Preference ☐ Email ☐ Phone Age _____ Birthdate _____

Sex ☐ Male ☐ Female Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Number of children _____

Age(s) of children _____ Children with special needs? ☐ Yes ☐ No

Occupation _____ Do you enjoy your job? ☐ Yes ☐ No ☐ Sometimes

Spouse's Name _____ Spouse's Occupation _____

Ethnic Background (where your family is originally from) and Birthplace: _____

Briefly describe where you have lived since childhood: _____

Personal Stats

Weight (Current) _____ 6 months ago _____ 1 year ago _____

Ideal Weight _____ Body Fat (if known) _____ Height _____

Please list your top 5 chief health concerns: physical, mental, emotional or spiritual:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list your top 5 health goals: physical, mental, emotional or spiritual:

1. _____

2. _____

3. _____

4. _____

5. _____

List things / programs you've tried and failed or have not given you the results you'd hoped for:

1. _____

2. _____

3. _____

List 3 things you're willing to do to solve you're problems / main complaints:

1. _____

2. _____

3. _____

How are you going to reward yourself once you achieve your goals?

_____

Other concerns, physical or emotional/ spiritual? Please be as specific as possible:

_____

Any additional information you'd like to share?

_____

_____

_____

Long distance clients: you're welcome to send Dani a photo of yourself (from waist up if possible) via email to: Dani@NutritiontheNaturalWay.com

Medical History

Are you currently under the care of a medical doctor? ☐ Yes ☐ No May I contact your doctor if necessary? ☐ Yes ☐ No

If yes, what are you being treated for?

If no, when was your last physical examination?

Are there any other healers, helpers, or therapies in which you are involved (acupuncture, massage, therapy, energy work, other doctors or ND/ specialist, etc.)? Please list with "present" or year of previous treatment

Have you used birth control pills and / or antibiotics? ☐ Yes ☐ No

For how long and how many times throughout your entire life?

Have you been treated for yeast infections and/ or ever treated them on your own? ☐ Yes ☐ No

Last Cholesterol reading and date: Blood Type:

Describe dental history including cleanings, fillings (type), infections, cavities, root canals:

Do you have any pain, stiffness or swelling in your body? ☐ Yes ☐ No Where?

Average amount of sleep per night? Wake often? ☐ Yes ☐ No Stay asleep? ☐ Yes ☐ No

Have you ever been diagnosed with an auto immune disease(s)? Please list year of diagnosis and a brief history about your experience with it/ them:

(Women Only) Period overview: Regular? ☐ Yes ☐ No Days of Flow ☐ Light ☐ Heavy

How Frequent? Painful or Symptomatic? ☐ Yes ☐ No If yes, please explain

Clotting Yes ☐ No ☐

Perimenopause ☐ Yes ☐ No Menopause ☐ Yes ☐ No Periomenopause or Menopause, date of last cycle?

Are you presently taking any medications, nutritional supplements or vitamins? ☐ Yes ☐ No If yes, please list them below

Vitamins/Food Based	Prescription Medications	Over the Counter Medications	Other (this includes marijuana)

Do you presently, or have you ever had any of these conditions?

- ☐ Anemia
- ☐ Joint Pain/ Arthritis
- ☐ Asthma
- ☐ Chest Pains
- ☐ Chronic Cold/ Flu Symptoms
- ☐ Chronic Fatigue
- ☐ Constipation/ Loose Stools
- ☐ Depression
- ☐ Diabetes
- ☐ Frequent Headaches
- ☐ Heartburn/ Indigestion
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormonal Imbalance
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ PMS or Menopausal Symptoms
- ☐ Skin Condition (dandruff, dry/ itchy)
- ☐ Thyroid Condition
- ☐ Unexplained Weight Change

Do you have any known food allergies, sensitivities or restrictions?

Please list any current or past diseases, viruses or infections and corresponding age. This should be a history of your life from childhood to present day, including but not limited to: Mononucleosis, Chicken Pox, Pneumonia, Strep Throat, MRSA, Giardiasis, Cold Sores, Herpes, HPV, Coronavirus, Warts, Ulcers, UTIs, Impetigo, Staph, Malaria, Lyme Disease, Salmonella, Candidiasis:

Disease	Past or Current	Age

Please list any past or current diseases or disorders that run in your family, with the family member affected:

Please list any hospitalizations and surgeries, starting with most recent:

Please check any that generally apply to you. If female, please mark if they are pre-menstrual/menses symptoms:

- ☐ Feel cold often
- ☐ Dislike the heat
- ☐ Sweaty palms or soles of feet
- ☐ Cramping
- ☐ Highly emotional
- ☐ Mental Fogginess
- ☐ Low back pain
- ☐ Mucus Issues
- ☐ Rosacea
- ☐ Constipation
- ☐ Stomach aches
- ☐ Dark urine
- ☐ Heart burn / Acid Reflux
- ☐ Heart concerns
- ☐ Insulin Resistance
- ☐ Brittle nails
- ☐ Dislike the cold
- ☐ Night sweats
- ☐ Cold hands or feet
- ☐ Moodiness/Irritable
- ☐ Easily overwhelmed
- ☐ Memory issues
- ☐ Neck/ Shoulder pain
- ☐ Dry, cracked skin
- ☐ Psoriasis / Eczema
- ☐ Diarrhea
- ☐ Food sensitivities
- ☐ Floating stool
- ☐ Insomnia
- ☐ Respiratory concerns
- ☐ Infertility
- ☐ Premature lip wrinkles ("smoker's wrinkles" but don't smoke)
- ☐ Feel hot often
- ☐ Daytime sweats
- ☐ Breasts Tender
- ☐ Anxiety
- ☐ Depression
- ☐ Dizzy
- ☐ Ringing in the ears
- ☐ Dry, itchy skin
- ☐ Acne/Skin eruption
- ☐ Gas / Bloating
- ☐ Frequent urination
- ☐ Mucous in stool
- ☐ Headaches
- ☐ Water retention
- ☐ Hair loss

How is your energy level?

☐ Great ☐ Good ☐ Fair ☐ Poor What times of the day that you feel the best? worst?

Check off any of the following gut health symptoms that have applied to you **within the last year:**

- ☐ Weight gain/ inability to lose weight
- ☐ Bloating after meals
- ☐ Constipation
- ☐ Stools compact/ hard to pass
- ☐ Infertility
- ☐ Hair loss
- ☐ Auto Immune Diagnosis
- ☐ Depression/ mood changes
- ☐ Abdominal/ intestinal pain
- ☐ Heartburn/ Acid Reflux
- ☐ Travel outside the U.S.
- ☐ Belching after meals
- ☐ Skin rashes / other skin issues
- ☐ Viruses/ viral infections
- ☐ Insomnia (any sleep issues)
- ☐ Feeling anxious/ anxiety
- ☐ Consistent bloating
- ☐ Diarrhea
- ☐ Nausea / gas
- ☐ Stomach gurgles
- ☐ Energy problems
- ☐ Auto immune symptoms
- ☐ Abnormal thyroid markers

If you indicated on the previous page that your energy is compromised, please complete this page. If not, skip this page.
Next to each question assign a number between 0 and 5. You should assign values as follows:
0 = Not true 3 = Somewhat true 5 = Very true

Once you have completed the questionnaire calculate your total below.

_____ I experience problems falling asleep.

_____ I experience problems staying asleep.

_____ I frequently experience a second wind (high energy) late at night.

_____ I have energy highs and lows throughout the day.

_____ I feel tired all the time.

_____ I need caffeine (coffee, tea, cola, etc) to get going in the morning.

_____ I usually go to bed after 10 pm.

_____ I frequently get less than 8 hours of sleep per night.

_____ I am easily fatigued.

_____ Things I used to enjoy seem like a chore lately.

_____ My sex drive is lower than it used to be.

_____ I suffer from depression, or have recently been experiencing feelings of depression such as sadness, or loss of motivation.

_____ If I skip meals I feel low energy or foggy and disoriented.

_____ My ability to handle stress has decreased.

_____ I find that I am easily irritated or upset.

_____ I have had one or more stressful major life events. (ie: divorce, death of a loved one, job loss, new baby, new job)

_____ I tend to overwork with little time for play or relaxation for extended periods of time.

_____ I crave sweets.

_____ I frequently skip meals or eat sporadically.

_____ I am experiencing increased physical complaints such as muscle aches, headaches, or more frequent illnesses.

_____ **Please add up your score here**

Describe the health of your mother. If deceased, describe how her health was and age of passing:

Describe the health of your father. If deceased, describe how his health was and age of passing:

*Please note that the answers to the questions below are important in relation to your current digestion. Do your best to obtain the answers from parents, siblings, family members or other care givers who are still in your life today.

Were you carried "full term" in vetro? ☐ Yes ☐ No If not, how prematurely were you born?

Were you nursed or bottle fed? If nursed, how long?

What age were solid foods introduced to your diet?

Lifestyle Reflection

Do you smoke, drink alcohol or use recreational drugs?

If yes, how much and how often?

How often do you drink caffeinated beverages?

What do you drink and do you add anything else to the drink?

Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):

What foods do you eat on a daily basis?

Do you "miss" these foods if you do not eat them?

Write briefly about your weight gain/loss history:

What do you feel triggered your weight fluctuation? Was your weight gain/ loss:

☐ Hereditary ☐ Stress ☐ Eating Habits ☐ Boredom ☐ Sudden ☐ Gradual ☐ Problem since childhood

Are you happy in your life right now?

Stress level 1-10?

What are your main sources of stress?

How do you deal with your stress?

Please answer the following questions yes or no:

If I'm feeling down, a snack makes me feel better. ☐ Yes ☐ No

I sometimes have a hard time going to sleep without a bedtime snack. ☐ Yes ☐ No

I get tired and/or hungry in the mid-afternoon. ☐ Yes ☐ No

I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. ☐ Yes ☐ No

Now and then I think I am a secret eater. ☐ Yes ☐ No

At a restaurant, I almost always eat too much bread before the meal is served. ☐ Yes ☐ No

I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. ☐ Yes ☐ No

I experience cravings for sugar, breads, pasta and baked goods. ☐ Yes ☐ No

I feel shaky if I don't eat on time or if I don't snack. ☐ Yes ☐ No

I often find myself irritable or angry. ☐ Yes ☐ No

In your estimation, how physically fit are you right now?

☐ Unfit ☐ Below Average ☐ Average ☐ Above Average ☐ Very Fit

How often do you exercise?

Regimen/ describe roll exercise plays in your life

If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

What are your fitness goals? (Check all that apply)

☐ General fitness endurance
☐ Weight loss/maintain weight
☐ Muscular coordination/balance
☐ Other:

☐ Muscular coordination/balance
☐ Osteoporosis prevention
☐ Specific sport enhancement

☐ Muscle strengthening
☐ Muscle Toning
☐ Flexibility

Describe your relationship with food:

What foods did you eat as a child?

Did you eat dinner as a family as a child? ☐ Yes ☐ No

Was food a positive experience for you growing up? ☐ Yes ☐ No

What percentage of your food is home cooked? % Do you enjoy cooking?

Where does the rest of the food you eat come from?

Who does the cooking in your household?

Do you cook in the microwave? If yes, how often?

Do you use Aluminum or Teflon Cookware? ☐ Yes ☐ No

Has your eating changed much in the past year? If so, how?

Is your diet mostly cooked, raw or a combination? Describe:

Do you buy organic? ☐ Yes ☐ No Which foods do you buy organic?

Typical list of fruits and veggies you eat?

Please circle the foods you eat on the following chart. Place an "O" next to the food for often (3-5+ times per week) or "S" for sometimes < 3 times per week).

- ☐ Beef ____
- ☐ Cookies/Candy ____
- ☐ Margarine/Shortening ____
- ☐ Cheese ____
- ☐ Butter ____
- ☐ Salty Fish/Sushi or raw meat ____
- ☐ Beans ____
- ☐ Tofu or Tempeh ____
- ☐ Quinoa ____
- ☐ Cow Milk ____
- ☐ Chicken ____
- ☐ Spicy Foods ____
- ☐ Bitter Foods ____
- ☐ Yogurt or ice cream ____
- ☐ Brown or White Rice ____
- ☐ Nut butters/Tahini Amaranth ____
- ☐ Millet/Buckwheat ____
- ☐ Oats ____
- ☐ Pastries ____
- ☐ Goat milk products ____
- ☐ Pork ____
- ☐ Eggs ____
- ☐ Sweet and Sour ____
- ☐ Wheat bread ____
- ☐ White or Wheat pasta ____
- ☐ Miso ____
- ☐ Nuts and/or seeds ____

Jumpstart Session Agreement

Date: _____

I _____, (hereinafter "Client") confirm I am electing to purchase a Nutrition & Wellness Jumpstart Session with Dani Conway of Perpetual Synergy, DBA Nutrition the Natural Way, a California LLC (hereinafter "Coach"). In exchange, Coach agrees to provide the services outlined below. Client understands and agrees that Coach will utilize suitable methodologies in accordance with Client's needs, and in accordance with her training as a CHEK Holistic Lifestyle Coach, Advanced Metabolic Typing Advisor, Kalish Method Practitioner and Functional Diagnostic Nutrition Practitioner.

Payment

Client confirms the cost of this Nutrition & Wellness Jumpstart Session is a non-refundable one hundred forty nine U.S. dollars ($149), payable via Venmo, Paypal, Visa or Mastercard and is due within 48 hours of scheduling the session. If Client has not completed payment within 48 hours of scheduling the session, Client understands Coach will not be able to hold the appointment, and it will be postponed until Client is able to complete payment to Coach. If there is another circumstance, please communicate this to Coach for consideration for payment time frame.

Confidentiality

Coach understands she will likely learn confidential information about Client during the session, and Client understands she will learn information only shared with Coach's paying clients. This Agreement is considered a mutual non-disclosure agreement, meaning both Client and Coach agree not to disclose, reveal, or make use of any confidential information learned by either party during discussions, including but not limited to medical information, personal information, Coach's proprietary nutritional methods, and the like. Client and Coach agree that the responsibility to refrain from disclosing or sharing any and all Confidential Information learned as a result of Client working with Coach shall survive the expiration of this Agreement and Coach's services. This means Client and Coach both agree to continue to keep Confidential Information private, even after the completion of working with Coach.

Medical Disclaimer

The purpose of this session is to provide Client individualized nutrition and wellness next step Program items, along with recommendations for future programming specific to Client. Program and content contained within the Program is not to be considered medical advice, and nothing within the Program is intended to provide or act as a substitute for medical treatment. Coach encourages Client to consult a physician if he/she suspects he/she may benefit from such services. Coach will assume Client has previously obtained clearance and permission from their applicable personal medical physician, who has concluded that the information provided by Coach is right for them. Nothing contained within Program is intended to diagnose, cure, treat, or prevent any medical condition or disease, nor is it to be considered medical advice in any capacity.

Disclaimer / No Guarantees

While many of Coach's past and current clients have experienced wonderful benefits from the Program, and Coach and his/her team will act in their full capacity to ensure your success and happiness in the Program, Coach cannot guarantee results of the Program, and cannot make any representations or guarantees regarding individual results. Client will hold Coach and Program harmless if he or she does not experience the desired results. Client understands that all services provided by Coach in connection with the Program being purchased are provided on an "as is" basis, meaning it is without any guarantees, representations, or warranties, including but not limited to warranties relating to quality, non-infringement, fitness for a particular purpose, merchantability, or expectation or course of performance. Client is choosing to purchase this call and work with Coach on a purely voluntary basis and does not hold Coach or Program responsible should Client become dissatisfied with any portion of the Program.

Client agrees that he/she does not have a cause of action, legal remedy, and is not entitled to a refund should he/she not achieve the results desired following completion of the program, as long as Coach delivers the Program as described in the Program Outline Addendum below, or similar substitutes, upon additional agreement by Coach and Client.

Jumpstart Session Agreement

Client understands he/she is electing to have this initial call for the purpose of achieving a desired health and/or fitness goal through Coach's Program. Client confirms he/she is choosing to do so voluntarily and of his/her own free will.

Client certifies he/she has or will be evaluated by his/her personal physician and obtain medical clearance prior to beginning any fitness, exercise, diet, health or wellness-related Program with Coach. If Client elects not to obtain this medical clearance prior to beginning Program, he/she understands the potential injuries and ramifications of such actions, and agrees not to hold Coach responsible for any such injuries or negative consequences. Client understands Program may include elements of diet and exercise, which bring inherent risks of illness, injury, or other similar unanticipated consequences. Client agrees he/she is aware of and assuming these risks in order to voluntarily proceed with Coach's Program. Should any such incidents occur, Client understands it is of no fault or responsibility of Coach, and agrees Coach is not liable.

Dispute Resolution

Should a dispute arise between Coach and Client, the parties agree to attempt to resolve by good-faith negotiations and discussions. (Client agrees that failure to see results is not a basis for a "dispute" and agrees he or she does not hold Coach responsible for any specific results, or those results which have been achieved by other clients of Coach.) If unable to reach a resolution informally, Client and Coach agree that all disputes will be submitted for Arbitration by the American Arbitration Association, to be completed in Sacramento, California within a reasonable amount of time. Client and Coach agree to participate in the arbitration process in good faith and in a manner that will effectively and efficiently resolve the dispute at hand, including the exchange of any materials, documents, or information. The decision made by the arbitrator is to be final and binding on both parties, and is not to be appealed or otherwise set aside. It is to be enforceable in any court of proper jurisdiction as a judgement of law or decree.

Applicable Law

This Agreement shall be governed by and under control of the laws of California regardless of conflict of law principles, and regardless of location of Client. Client understands this and agrees that the laws of California are to be applicable here.

Client Signature: _____

Date: _____