Dear Health Seeker,

Welcome to Stephanie Cowie's Holistic Nutrition and Natural Health Solutions.

Please fill out all of the forms included in this package and bring them to your first appointment.

Achieve Wellness Spa
206-112 Riverstone Ridge, Fort McMurray
(located above the Shopper's Drugmart)

If you are lost or running late please call the office at **780-750-3391**

I look forward to meeting you and guiding you on your health journey.

Sincerely,

Stephanie Cowie
Certified Nutritional Practitioner

Stephanie Cowie M.Ed. CAHP NNCP CNP
Clinical Nutrition and integrative health care

On the day of your appointment

Please read the following instructions carefully.

1.) Please do not eat or drink anything one hour prior to your appointment. No mints, chewing gum or candies one hour prior to your initial appointment. Water is permitted. You may bring a snack to the session to consume after the test.

2.) I will need a urine sample from you. You have two options:
   1.) The preferred method for better results is to bring me a first morning urine sample in any clean glass jar from your house. Please refrigerate the sample until you come for your session especially if you have an appointment in the afternoon or evening. Please do not consume alcohol the night before if possible as it can alter the results.
   2.) **OR** you can provide a urine sample during the session. If you choose this option please drink enough water prior to the session to be able to provide a urine sample.

3.) Please bring all of your completed forms with you to the session.

OPERATIONAL GUIDELINES

1. "I am not a medical doctor. I am not legally permitted to treat diseases. I can however, advise you with respect to building and maintaining wellness."
2. "If you have a condition requiring medical attention that is a matter between you and your medical doctor. Legally, I am not permitted to advise you on it. My concern is to help you to discover and support your unique nutritional weaknesses."
3. I am not legally authorized to diagnose your condition. For that you need to consult a licensed physician. I can, however, give you guidance about giving your body the nutrients it needs to do its own normalizing, regardless of what condition in may be in."

NUTRITIONAL CLIENT STATEMENT

I hereby attest to the following:

1. That I am here, on this and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial, municipal or professional agency on a mission of entrapment or investigation.
2. I fully understand that Stephanie Cowie is not a medical doctor and I am not here for medical diagnostic or treatment procedures.
3. The services provided by Stephanie Cowie are at all times restricted to consultation on the subject of nutritional matters intended for general nutrition well-being and do not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of any disease, or any licensed or controlled act which may constitute the practice of medicine in this province.
4. This agreement is being signed voluntarily and not under duress of any kind.
5. I give consent for Stephanie Cowie to perform basic physical assessments including blood pressure, heart rate, eye analysis, finger nail analysis, a visual inspection of the oral cavity, zinc tally test, adrenal urine test and/or urinary indican test.

CANCELLATION POLICY

A cancelled appointment delays our work. When you must cancel, please give me at least 24 hours notice. I am rarely able to fill a cancelled session unless I know at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, you will be charged 50% of your appointment fee. The only time I will waive is fee in the event of serious or contagious illness or emergency. _____ (Please initial)

Signature: _____ Name: _____

Address: _____ City_____ Province _____

Postal code _____ Tel. #: _____

Date: _____

Name: _____ Date: _____

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 days including one weekend day.

- Write down everything you eat and drink, the place of consumed it, and any moods/symptoms felt throughout the day
- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g. milk – what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with 2 sugars)
- Recording exact portion sizes are not necessary; try to give an approximation (i.e. 1 bowl of homemade tomato soup)
- Days do not have to be consecutive.

DAY 1

Time	Place	Food/Drink	Mood/Symptoms

SLEEP

Duration	:	to	:	Quality	

EXERCISE

Time	Place	Duration	Type

DAY 2

Time	Place	Food/Drink	Mood/Symptoms

SLEEP

Duration	: to :	Quality	

EXERCISE

Time	Place	Duration	Type

DAY 3

Time	Place	Food/Drink	Mood/Symptoms

SLEEP

Duration	: to :	Quality	

EXERCISE

Time	Place	Duration	Type

GENERAL INFORMATION

Please fill in the form below and bring it to the first appointment.

Name *First* _____ *Middle* _____ *Last* _____

Date _____

Primary Address *Number, Street* _____ *Apt, No.* _____

City _____ *Province* _____ *Postal code* _____

Hone Phone _____

Work Phone _____

Cell Phone _____

Fax _____

Email _____

Date of Birth _____

Age _____

Gender ☐Male ☐Female

Height _____

Weight _____

Blood Type ☐A ☐B ☐AB ☐O ☐Rh+ ☐Unknown

Genetic Background ☐African ☐European ☐Native American ☐Mediterranean
☐Asian ☐Ashkenazi ☐Middle Eastern ☐_____

Highest Education Level ☐ High School ☐ Under-Graduate ☐ Post-Graduate

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Job Title _____

Nature of Business _____

Referred by _____

Stephanie Cowie
CERTIFIED NUTRITIONAL PRACTITIONER

ORAL THERAPIES

List all prescription medications, over-the-counter medication, and natural oral therapies you are currently taking.

Prescription Medications or Over The Counter Medications	Reasons For Talking

Vitamins, Herbal or Homeopathic Medicines	Brand	Dosage

HEALTH RECORD – CONFIDENTIAL INFORMATION

Allergies

Medication/Supplement/Food	Reaction

Complaints/Concerns

Main Health Complaint / Symptoms:

What is your purpose in coming here today?

Any trauma or loss in 5 years?

Have you ever been diagnosed with and illness? If yes, why?

Have you ever been drug and/ or alcohol dependent? ☐ Yes ☐ No

When did your illness first begin?

Did something trigger your change in health?

When was the last time you felt well?

What makes you feel worse?

What makes you feel better?

Oral Therapies

Rx Medications/OTC Meds/Recreational Drugs:	OTC drugs, vitamins, herbal or homeopathic medicines you are taking and the dosages:

Family History

Family Member	Age	Health Status
Father		
Mother		
Brother(s)		
Sister (s)		

Hereditary Diseases: Use “F” for father, “M” for mother, “S” for sibling, “G” for grandparent,

“O” for others

_____ Heart Disease _____ Diabetes _____ Allergies

_____ Hypertension _____ Arthritis _____ Mental Illness

_____ Intestinal Disease _____ Osteoporosis _____ Alcoholism

_____ Kidney Dysfunction _____ Ulcers _____ Asthma

_____ Gull Bladder Problem _____ Cancer, type: _____

Other (please list) _____

_____

_____

_____

Have you ever been hospitalized? If yes, when? Why?

Surgeries (appendix, GB, tonsils):

Vaccinations or Flu shots and when?:_____

Symptomatology Assessment

Based upon your typical health profile and current health status; rate each of the following symptoms according to the following point scale. Do you suffer from or have a history of any of the following conditions or symptoms?

Please indicate your score of 0-4 <u>in BOX #1 ONLY</u> (BOX #2 and BOX #3 are for further appointments)

0 = Never have it – if so, leave the space blank
1 = Mild or Occasionally have it
2 = Moderate, Happens more frequently
3 = Severe, Happens all the time
4 = Extremely severe, Always Present

1	2	3	Cardiovascular/Circulation	Comments
			Heart Condition/Angina/Stroke	
			Heart Palpitations / tachycardia (racing)	
			Elevated Cholesterol	
			Low blood pressure	
			Orthostatic hypotension	
			Hypertension (High Blood Pressure)	
			Rheumatic fever	

1	2	3	Cardiovascular/Circulation	Comments
			Mitral valve prolapsed	
			Tingling arms or legs	
			Arms and legs often go to sleep	
			Chest Pain or Tightness	
			Weakness or Low Energy	
			Circulation problems	
			Cold hands & feet	
			Edema (water retention)	
			Leg / Ankles swelling	
			Ringing in ears (Tinnitus)	

1	2	3	Metabolic/Endocrine	Comments
			Diabetes (Type I or Type II)	
			Hypoglycemia	
			Metabolic syndrome (Insulin Resistance or Pre-Diabetes)	
			Dizzy periods or blackouts	
			Sudden weakness & shakiness	
			Experience hunger after eating	
			Experiencing hunger almost constantly	
			Irritable if late for or missed meal	
			Craving: sweets, alcohol, coffee, salty	
			Wake up at night feeling hungry	
			Overweight, can't lose	
			Weight loss	
			Frequent weight fluctuations	
			Feel better when don't eater	
			Poor appetite / picky eater	
			Anorexia / Bulimia	
			Binge eating disorder	
			Night eating syndrome	
			Hypothyroidism	
			Hyperthyroidism (Graves)	
			Chronic fatigue syndrome	

1	2	3	Connective Tissue	Comments
			Arthritis (Osteo/Rheumatoid)	
			Osteoporosis/Osteopenia	

1	2	3	Connective Tissue	Comments
			Fibromyalgia	
			Chronic pain	
			Bruise easily	
			Gums bleed / Nose bleeds	
			Joint pop or crack	
			Back pain	
			Neck or shoulder tension / pain	
			Achy or weak legs	
			Any other muscle pain?	
			Any other joint condition?	
			Problems w eyes/ Glaucoma / MD/ NightV.	
			Problems with hearing	

1	2	3	Autoimmune/Inflammatory	Comments
			Autoimmune disease	
			Frequent colds or infections: how many a year? ___ Flu shots? ___	
			Antibiotics___# of times in the past 5 yrs	
			Cortisone / NSAIDS / Analgesics # of years? ___ How often? ___ wk/mm	
			Herpes – genital/oral	

1	2	3	Respiratory	Comments
			Asthma	
			Bronchitis	
			Emphysema	
			Pneumonia	
			Tuberculosis	
			Sleep apnea	
			Chronic sinusitis	

1	2	3	Allergies	Comments
			Allergy / Hay fever	
			Sinus or Ear infections	
			Bags or dark circles under eyes	
			Itchy, stuffy or runny nose	
			Nose-throat congestion / mucous (type?)	
			Post-nasal drip	
			Dry / Irritated or Itchy eyes	

1	2	3	Kidney/Lymph	Comments
			Kidney / Bladder problems / infections	
			Swollen or tender glands	

1	2	3	Neurologic/Mood	Comments
			Concentration or memory problems	
			Parkinson's/MS/ALS/Seizures	
			Sleepiness (in afternoon? / After meals?)	
			ADHD /ADD	
			Migraines	
			Headaches – Throbbing / Stabbing	
			Insomnia – fall asleep / stay asleep	
			Restless sleep / other sleeping problems	
			Remember dreams?	
			Restless leg syndrome	
			Nightmares	
			Mood swings	
			Anxiety / panic attacks	
			Irritability / Nervousness	
			Depression / Sadness	
			Frustration / Anger	
			Biopolar / Schizophrenia	

1	2	3	Gastrointestinal	Comments
			Liver or Gall Bladder problems	
			Nausea or Vomiting	
			Ulcers / Gastritis (in past or present)	
			Bad breath	
			Heartburn / Gastric Reflux - GERD	
			Belching / Burping	
			Gas and bloating – when?	
			Stomach cramps / Abdominal pains	
			Diarrhea	
			Constipation	
			Hemorrhoids / Varicose Veins	
			Celiac Disease	
			Ulcerative Colitis / Crohn's Disease	
			Irritable Bowel Syndrome (IBS)	
			Diverticulosis / it is	

1	2	3	Gastrointestinal	Comments
			Itchy anus, nose or ears	
			Any other gastrointestinal condition?	

Foreign Travel? ☐ Yes ☐ No Where? _____

Wilderness Camping? ☐ Yes ☐ No Where? _____

Bowel Movements:

Please fill in the boxes and circle the descriptions that apply.

Frequency (how many times per day?)	Consistency	Contents	Length	Texture	Color	Time of day	Toilet Paper Used Per BM
	Hard dry Firm Watery Soft	Stringy Mucous Floating Blood Undigested food	Longer than 6” 6” Shorter than 6” Small bits Pellets	Smooth well-formed Threads Lumps linked together	Light brown Yellowish Brown Dark brown Green Black		-Lots -Little

Bowel Movement Summary:_____

1	2	3	Skin	Comments
			Melanoma / Skin cancer	
			Acne / Goosebumps on triceps/thigh	
			Psoriasis / Eczema	
			Hives	
			Dermatitis	
			Fungal infections (athletes foot / jock itch)	
			Skin infections / Rashes	
			Itching skin	
			Dry skin / Scaling skin	
			Any other skin condition? _____	
			Loss of hair	
			Nails break, split, or peel	
			White spots on nails	

Menstrual History

Age of first period:____ Menses frequency:_____ Length:_____ Pain: ☐Yes ☐No Clotting: ☐Yes ☐No

Has your period ever skipped? _____ For how long? _____

Last menstrual period: _____

Use of hormonal contraception such as: ☐ BCP ☐ Patch ☐ Nuva ring ☐ IUD How long? _____

1	2	3	Females	Comments
			P.M.S. – A C D H – Day ____to____?	
			Yeast Infections / Vaginal-itch or discharge	
			Difficulty conceiving / Infertility – Age ___?	
			Pregnancies	
			Toxemia/Ges, diabetes/Baby over 8 lbs	
			Caesarian	
1	**2**	**3**	**Females**	**Comments**
			Post partum depression	
			Breast feeding – How long?	
			Miscarriage/Abortion – Age ____?	
			Hysterectomy – Age ____?	
			Uterine fibroids – Age ____? Size____?	
			Ovarian Cysts – L / R Size____? #____?	
			Cervical Dysplasia – Age____?	
			Fibrocystic Breasts – L / R – Age ___?	
			Decline in sexual interest, feelings	
			Pregnant or lactating	
			Breast cancer Dx ____ Stage____	
			STD/STI	

Last Mammogram: _____ ☐ Breast Biopsy/Date: _____

Last PAP Test: _____ ☐ Normal ☐ Abnormal

Are you pre-menopausal or menopausal? ☐ Yes ☐ No

Are you experiencing any menopausal symptoms? ☐ Yes ☐ No

If yes, please specify _____

Age at menopause _____

☐ Hot flashes ☐ Mood swings ☐ Concentration/Memory Problems ☐ Vaginal dryness ☐ Decreased libido

☐ Heavy bleeding ☐ Joint paints ☐ Headaches ☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

☐ Use of HRT. How long? _____

1	2	3	Males	Comments
			Difficult urination, starting or burning	
			Get up at night to urinate #_____?	
			Back or Leg pains	
			Prostate trouble/cancer	
			Diminished sex drive or Impotence	
			Poor sexual performance	
			Infertility	
			STD/STI	

Have you had a PSA done? ☐ Yes ☐ No

Have you done bone density test? ☐ Yes ☐ No

If yes, what was the result? _____

Birth History

☐ Term ☐ Premature

Pregnancy Complications: _____

Birth Complications: _____

☐ Brest Fed How Long? _____ ☐ Bottle-fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child: ☐ Yes ☐ No

Dental History

☐ Composite Feelings #_____ ☐ Gold Feelings # _____

☐ Root Canals: # _____ ☐ Implants ☐ Dentures ☐ Tooth Pain ☐ Bleeding Gums ☐ Gingivitis

☐ Mottled teeth ☐ Mouth ulcers/lesions ☐ Fissured/Scalloped/Coated Tongue ☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No

Nutrition History

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No Describe: _____

Do you currently follow a special diet or nutritional program?

☐ Low Fat ☐ Low Carb ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat ☐ Gluten Restricted

☐ Vegetarian ☐ Vegan ☐ Other: _____

Do you avoid any particular foods? Why? _____

_____

If you could eat a few foods a week, what would they be? _____

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you read food labels? ☐ Yes ☐ No _____

Do you cook? ☐ Yes ☐ No If no, who does the cooking? _____

How many meals do you eat out per week? _____

What are the most important things you think you should change about your diet to improve health? _____

_____

DIETARY HABIT

Do you eat meals: ☐ With family ☐ Home alone ☐ On the run ☐ Restaurant ☐ Fast food

Do you feel there are restrictions to your diet due to the preferences of others- Family, roommates, etc? ☐ Yes ☐ No

If yes, please explain _____

How many ½ cup servings of each do you typically eat in a day:

_____ Fruit: ☐ Fresh ☐ Dried ☐ Canned

_____ Vegetables: ☐ Cooked ☐ Raw

_____ Whole Grains

_____Protein: Type _____

_____ Dairy Products: Type _____

_____ Other: Specify _____

Do you eat or use? (indicate "1" for rarely, "2" for regularly, "3" for often)

Please indicate your score of 1-3 in BOX #1 ONLY (BOX #2 and BOX #3 are for further appointments)

1	2	3	Name	Comments
			Margarine	
			Candy	
			Fried foods	
			Refined foods	
			Luncheon meats	
			Fast foods	
			Nutra Sweet/Aspartame	

Please indicate how many cups of the following you drink per day?

_____ Bottled or spring water

_____ Fresh fruit juices

_____ Fruit juices *(prepared)*

_____ Fresh vegetable juices

_____ Soft drinks *(regular)*

_____ Soft drinks *(diet)*

_____ Tap water

_____ Beer

_____ Red wine

_____ White wine

_____ Other alcoholic

other *(specify)* _____

_____ milk *(1% or 2%)*

_____milk *(skim)*

_____ tea

_____ herbal tea

_____ coffee

Are you a? ☐ Meat eater ☐ Vegetarian ☐ Vegan

How often do you eat meat? ☐ Daily ☐ 3-5/week ☐ Once/week or less

How often do you consume dairy products? ☐ Daily ☐ 3-5/week ☐ Once / week or less

What are your favourite foods? _____

How often do you eat them? _____

Do you experience any symptoms if meals are missed? Explain:

_____

Do you experience any symptoms after meals? Explain:

_____

Smoking

Currently smoking? ☐ Yes ☐ No How many years? _____ Packs per day: _____

If no, does anyone in your household or workplace smoke? ☐ Yes ☐ No

Attempts to quit: _____

Previous smoking: How many years? _____ Packs per day:_____

Second Hand Smoke Exposure? _____

Alcohol Intake

How many drinks currently per week? _____ Type _____

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

Other Beverages

Coffee ___ Tea ___ Water ___ Tap / Brita / other: _____ Milk ____ Wine ___ Fruit J. ___ Vegetable J. ___

Juice Y/N Herbal Tea ___ Soft drinks ___ Other: _____ Chew Gum: _____

Exercise

What do you do for exercise? _____ Frequency: _____

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

List problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

_____

Do you usually sweat when exercising? ☐ Yes ☐ No

Psychosocial/Stress/Coping

What level of stress do you feel you are experiencing at this time?

☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

Do any events/moments in your life stand out as being more stressful? _____

What do you worry about in your life? _____

What do you do to relieve stress and relax? _____

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is currently reducing the quality of your life? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No ☐ Sometimes

How many hours each day do you work? _____

At what times do you start and end work? _____

Do you wish to gain weight? Lose weight? How much? _____

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

What are the major causes of your stress? ☐ Financial ☐ Career ☐ Personal

How does your stress manifest itself? _____

Daily Stressors: Rate on a scale of 1-10

Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often: _____

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☐ Yes ☐ No

What are your hobbies? _____

Do you vacation regularly? ☐ Yes ☐ No

When was your last vacation? _____

Sleep

How many hours on average do you sleep daily? (include naps) _____

What time do you go to sleep? _____ Awaken? _____

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

Describe your sleeping routine: _____

_____

_____

_____

Roles/Relationship

☐ Single ☐ Married ☐ Divorced ☐ Long/Short Term Partnership ☐ Widow

List Children:

Child's Name	Age	Gender

Who is living in household? Number: _____

Environmental and Detoxification Assessment

Are you able to go to sleep after consuming caffeine? ☐ Yes ☐ No

Do you adversely react to:

☐ MSG ☐ Aspartame ☐ Bananas ☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate) ☐ Other: _____

Which of these significantly affect you?

☐ Cigarette smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

In your home or work environment, are you exposed to: ☐ Chemicals ☐ EMFs ☐ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides/Insecticides/Pesticides ☐ Organic Solvents ☐ Heavy Metals ☐ Other: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No What do you use to wash clothes at home? _____

Do you use fabric softener? ☐ Yes ☐ No Do you have pets or farm animals? ☐ Yes ☐ No

What kind of cookware do you use? _____ Microwave? ☐ Yes ☐ No

What do you clean the house with? _____ House built before 1950? ☐ Yes ☐ No

Do you use makeup? ☐ Yes ☐ No Do you have a shower chlorine filter? ☐ Yes ☐ No

Do you use air fresheners? ☐ Yes ☐ No

Have you done any home improvement lately? ☐ New carpets ☐ Painting ☐ New furniture ☐ Other: _____

How many hours do you spend daily on average?

Driving _____ Watching television _____ Reading _____ In front of computer _____ Mobile phone _____

Where do you keep your phone? _____

Physical Assessment

Eyes: _____

Skin: _____

Nails: _____

Mouth: _____

Teeth: _____

Zinc Taste Test: Response 1 2 3 4 BP: 1.___ /___ 2.___ /___ 3.___ /___HR:1.____ 2.____ 3.____

Anthropomorphic							
BMI - Body Mass Index				WC - Waist Circumference			
WHR - Waist to Hip Ration	Waist:_____ Hip:_____ Ratio:_____						