Sutter Health
Institute for
Health & Healing

Name_____
MRN _____
Date of Birth _____

Institute for Health & Healing Clinic

Goals for Nutrition Consult:

_____

Please list any vitamins, supplements or herbs you are currently taking:

_____
_____
_____

Health Habits –

Food allergies or intolerances -_____
Food you choose not to eat - _____
Exercise _____
Beverages caffeine _____, alcohol _____, soda _____, water _____

Sample Diet -Please write down all the food and drink you consume over the next two days.

Day 1 Breakfast	Day 2 Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks/drinks	Snacks/Drinks

Consent to Receive Nutrition Counseling

I understand nutrition consultations are not a substitute for medical diagnosis or medical treatment, and that it is recommended I see a primary health care provider as needed. I have stated all medical conditions I am aware of and all medication I am currently taking. I consent to treatment and release the Institute for Health & Healing and its practitioners from any and all claims of damages for any injury, which may result from treatment. I understand all of my personal information provided here is strictly confidential.

_____ _____

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Patient/Guardian Signature

Date