# CLIENT INTAKE FORM

First Name Last Name

Address

Phone Email

**EMERGENCY CONTACT**

Name Phone

GP Contact:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Center\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your Age:\_\_\_**

**Your height:\_\_\_\_\_\_\_\_**

**Your current weight: \_\_\_\_\_\_\_**

**How long have you been in this weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Changes in weight in the past:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State the nature of the problem in your own words:**

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**What is your most difficult relationship right now?**

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**What is your most difficult emotion right now?** ...................................................................................................................................

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**Any problems with eating?** Sleeping / Chronic Pain / Recent Weight Loss

Describe any answers ticked…………………………………………………………………

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**Any other medical problems?**

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**TICK ALL CONDITIONS THAT APPLY NOW. PUT “P” FOR PAST CONDITIONS.**

* Heart, circulatory problems
* High/Low blood pressure
* Varicose veins
* Blood clots
* Phlebitis
* Infectious disease
* Skin disorders
* Allergies
* Diabetes
* Pregnancy
* Cancer/tumors
* Asthma/ Lung conditions
* Hernias
* Abdominal/digestive condition
* Arthritis
* Numbness/Tingling
* Muscle/bone injuries
* Muscle or joint pain
* Chronic pain
* Headaches or migraines
* Vision problems/contact lenses
* Hearing problems
* Fatigue
* Depression
* Seizures
* Stroke
* Previous motor vehicle accident
* Accident/trauma
* Prosthesis or denture
* Epilepsy
* Schizophrenia
* Insomnia
* Eating disorder (provide details\_\_\_\_\_\_\_\_\_\_\_\_

**Current medications, including aspirin, ibuprofen, herbs, vitamins, etc:** ………………………………………………………………………………………………

………………………………………………………………………………………………

**Do you smoke, drink alcohol or take recreational drugs?**

Yes…………..No………...If yes, provide some detail for what, how often and how much do you consume on a regular basis

………………………………………………………………………………………………

………………………………………………………………………………………………

**Any Irrational fears/phobias** (e.g. heights, spiders, needles, blood, knives, number 13, etc)

Yes…………..No………...If yes, provide detail

………………………………………………………………………………………………

**Do you find yourself compulsively checking things like the stove, lights, doors, keys etc?**

Yes…………..No………...If yes, provide detail

………………………………………………………………………………………………

**Do you have ceremonies or rituals (e.g. turning socks inside out and back again, washing hands frequently and excessively, etc)**

Yes…………..No………...If yes, provide detail

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# Weight Management – Overeating Profile

Read each of the following items below and then rate the examples on a scale of 1 (lowest) to 10 (highest) according to how likely they are to cause you eat inappropriately, or to accompany inappropriate eating.

**Social**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Arguing or having conflict with someone.  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2 | Being with other when they are eating. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3 | Being urged to eat by someone else. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4 | Feeling inadequate around others. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Emotional**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Feeling bad, such as anxious or depressed. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2 | Feeling good, happy and relaxed. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3 | Feeling bored or having time on my hands. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4 | Feeling distressed or excited. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Situational**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Seeing an advertisement for food. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2 | Passing a bakery, cookie shop or either enticement to eat. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3 | Being involved in a party, celebration or other special occasion. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4 | Eating out. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Thinking**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Making excuses for myself about why it’s okay to eat. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2 | Berating myself for being so fat or unable to control my eating. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3 | Worrying about others or about difficulties I am having. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4 | Thinking about how things should or shouldn’t be. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Physiological**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Experiencing pain of physical discomfort. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2 | Experiencing trembling headache or light-headedness associated with not eating or too much caffeine. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3 | Experiencing fatigue or feeling overtired. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4 | Experiencing hunger pains or urges to eat even though I’ve eaten recently. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

# WELL FORMED OUTCOMES - LAYING THE BASIS FOR CHANGE

For Client: Achieving healthy lifestyle involves change and it is important for you to identify whether you have any internal sub-conscious resistance to that change. This will be felt as internal conflict when you consider the answers to the following questions. Try to be as definitive as possible in answering them.

 Thus:

• What positive change(s) do you want for yourself?

• What will that do for you?

• In what way?

• What have you been getting out of what you have been doing up until now?

•

• How will you know when you have this change?

• How will others know?

• When do want the change to take place?

• Is there any context in which you don’t want it?

• For how long do you want the change?

• What is stopping you from making the change?

• What do you need to facilitate the change?

• What do you have already in terms of skills which can help?

• Is there anything you will lose as a result of the change?

• What will you gain by making the change?

• Is what you want worth wanting?

• How are you going to get there (expand and encourage yourself)?

• What qualities do you think you might need to develop to overcome the obstacles?

# User Agreement: My Food Romance

**Disclaimer / Terms and Conditions**

By taking part in this program you agree to take responsibility for your choices and actions aimed at achieving your health goal. Your active participation is the key to your success and success of this program. We can not do it for you, it is you who agrees to consider this information and healthy suggestions will make this happen.

The aim of this program is to inform you about healthy eating guidelines and help you understand and overcome any internal blocks and discover internal resources that will support your goals. The authors of this program do not accept any responsibility for your decisions in relation to your lifestyle, either positive or negative results, including ill health. All advice is based on evidence based research in nutrition and nutrition psychology. We do not heal, cure or promise any specific results.

Any advice is generic in nature and may not override or substitute medical advice. If you have a medical condition and follow your doctor prescriptions please continue until your doctor advises you otherwise. The information provided in this program is aimed at a reasonably healthy people and may not suit you if you have certain health restrictions and suffer from any acute or chronic health condition.

Participation in this program is not compulsory and fee-based. Any complains can be settled will a full refund of the fee you agreed to pay. By taking part in this program user agrees to never keep program facilitators responsible or liable for any loss or damage whatsoever either under this agreement or in relation to the provision of the information services.

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This is a place for gentle communication, any abuse or unsolicited advice or commercial advertising will be banned. We ask you to use polite language and be kind to yourself and others. Also be aware of the personal information shared on Facebook group or My Food Romance website as this is a public space and we can not warrant full confidentiality.

Any questions or concerns about this terms and conditions should be addressed directly to Elena Volodchenko and Valeriya Kovalyshen.

Cancellation Policy:

There is 7 days colling off period when you can receive full refund without providing any reason. After that the full fee is non-refundable