Steps To Change consultation agreement

Please read the following, and fill in the blanks as asked.

This Consultation Agreement is between _____(please insert your name) and Steps to Change. To ensure we are supporting you in the most comprehensive way possible, it is important to create a full picture of you, what has been happening over your life to create the current health concerns.

Your current health is a culmination of food and lifestyle choices, stress and its management, traumatic or horrible experiences, emotional dis-ease. Any recommendations are based on the information that you provide in this form, and what is discussed during the consultation. To ensure that the suggestions are effective as possible, it is vital to provide accurate information about your current eating, health history and your general lifestyle.

If you

- *have an illness that can be negatively affected by dietary modification* such as *Advanced Kidney Disease, Advanced Liver Disease or acute Allergies that require the use of an Epipen,* our services are not be suitable for you.

Client information management: Steps to Change collects and retains relevant medical information in electronic computer records, currently it is with Halaxaly.com and meets the Australian Medical privacy laws. If you consent to receiving our Newsletter, your name, and email address maybe held offshore dependent on the emailing service used. For more information please see our privacy policy available online

By signing this Consultation Agreement, you are aware of and are consenting to
Collection and storage of your details in a secure way according to the Australian Privacy ACT 2013

- Provide accurate information as inadequate or misleading information may result in inappropriate recommendations
- Take into consideration to your local food supply if you live outside of Australia, as food differs between regions and countries based on the farming, processing, manufacturing methods.
- Remission or cure is not a stated outcome; however, we focus on increasing awareness, management strategies and improved Quality of Life. At all times Steps to Change works towards supporting client's wellness, but it is the client who, just like athletes puts the effort in to create the change they desire.

I understand the above information and agree to engage Steps to Change's nominated wellness coach. I am aware I can cancel my Agreement with Steps To Change and/or unsubscribe from information feeds at any time. Any unpaid program fees will continue until the end of contract agreement.

Dated _____ Signature_____

If signing for a minor or as guardian:

Your name _____on behalf of _____

Relationship to client _____

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To help me understand your current health profile, please fill in the following details as accurately as possible, email back to Healthy Eats, or give to the Dietitian at the beginning of the consultation.

Completing this form will make it easier and speedier to give you information to support your health.

NEW CLIENT INFORMATION

Name: (Mr, Mrs, Miss, Ms)_____

Address:_____Post Code:_____

Telephone_____Mobile: _____

Preferred contact number_____ other_____

(Emergency Name and number)_____

Date of Birth:_____ Age:_____Occupation:_____

Email (optional)_____

Do you wish to be added to the general email with ideas, snippets and event invitations? Yes/No

Have you previously seen a Dietitian; Nutritionist, Naturopath? Yes/No If yes, why, and what was the advice?_____

How did you hear about the RECLAIMME! program?

Other Health Professionals you are currently seeing. If you choose for your wellness coach to communicate with your health professional to maximise your health management, provide their contact details

GP Name:_____***Address*** _____

_____Tel:_____Fax:_____

Psychologist/ counsellor:_____

Fitness Instructor or Fitness Program_____

Other health care providers:_____

Your medical history

Your current concern/s:_____

_____

Your goal/s or concerns you would like to address during the consultations:

1._____

2._____

3._____

Current prescribed medications prescribed by your Doctor/s:

Name	Dose	Name	Dose

The following pages help to narrow down symptoms relating to you, and for some highlight other possible triggers/drivers of your condition.

Please tick the following statements that are true to you, or the person you are representing for this consultation. If others in your family – parents, siblings experience these, then there may be a trigger for you that you are not aware of. Identify if it is you and them that experiences the following:

- ☐ Do you crave milk?
- ☐ Do you eat wheat and dairy foods?
- ☐ Do you seem agitated before consuming wheat or dairy products, and then spacey after eating them?
- ☐ Are you only beginning to look at diet for the first time for symptom management?
- ☐ Are you a picky eater – there are foods you refuse to eat?
- ☐ Have you been diagnosed with gut issues – (highlight which) IBS, Reflux?
- ☐ Have you previously trialled gluten and dairy free without success?
- ☐ Do you have trouble digesting grains?
- ☐ Do you eat meat?
- ☐ Do you have problem with urea build up, gout, crystals in joint or muscle?
- ☐ Do you have persistent Candida Jock Itch, Athletes Foot, Vaginitis?
- ☐ Have you been diagnosed with parasites, if yes, what_____.
- ☐ Have you lived, or worked near a major road way, industrial zone, aeroplane flight path?
- ☐ Is you work a hazard for chemicals, or heavy metals?
- ☐ Is your home, workplace or surrounding areas contaminated with mould, dampness or stank smell?
- ☐ Do you have bad smelling stool or gas?
- ☐ Do you sometimes act drunk, spacey or have maniacal laughter, but haven't consumed alcohol?
- ☐ Do you get itchy in moist areas of the body – elbows, knees or groin
- ☐ Do you eat vegetables?
- ☐ Are you uncomfortable or uninterested in restricting any foods to start?
- ☐ Do you want to start increasing levels of nourishment?
- ☐ Do you notice an oil spill like appearance on toilet water after going, or Grey stools?
- ☐ Do you eat animal products? Meat, Eggs, Cheese.
- ☐ Do you have an intolerance for milk or wheat products? Common symptoms bloating, sweet smelling flatulence, pain, faster defecation speed.
- ☐ Looking for a diet that can be implemented for the whole family
- ☐ Previous use of anti-biotics, for what _____*how many times have you used antibiotics*_____

SYMPTOMS RECORD,

Rate the following symptoms over the past seven days on a scale of 0 – 4 based on severity.
0 = none; 1 = some; 2 = mild; 3 = moderate; 4 = Severe (Based on the work of Dr Amy Myer)

Head
_____Headaches
_____Migraines
_____Faintness
_____Trouble sleeping
Total _____

Mind
_____Foggy brain
_____Poor memory
_____Impaired coordination
_____Difficulty deciding
_____Slurred/stuttered speech
_____Learning/attention deficient
Total _____

Eyes
_____Swollen, red eyelids
_____Dark circles under or around
_____Puffy eyes
_____Poor vision
_____Watery, itchy eyes
Total

Nose
_____Nasal congestion
_____Excessive mucus
_____Stuffy/runny nose
_____Sinus problems
_____Frequent sneezing
Total _____

Emotions
_____Anxiety
_____Depression
_____Mood swings
_____Nervousness
_____Irritability

Ears
_____Itchy ears
_____Earaches, infections
_____Drainage from ears
_____Ringing in ears, hearing loss
Total _____

Mouth, Throat
_____Chronic cough
_____Frequent throat clearing
_____Sore throat
_____Swollen lips
_____Canker sores/mouth ulcers
Total _____

Skin
_____Acne
_____Hives, eczema, dry skin
_____Hair loss
_____Hot flushes
_____Excessive sweating
Total _____

Weight
_____Inability to lose weight
_____Food cravings
_____Excess weight
_____Insufficient weight
_____Compulsive eating
_____Water retention, swelling

Other
_____Frequent illness, infection
_____Frequent urination
_____Genital itch, discharge
_____Anal itch
Total

Energy, Activity
_____Fatigue
_____Lethargy
_____Hyperactivity
_____Restlessness
Total _____

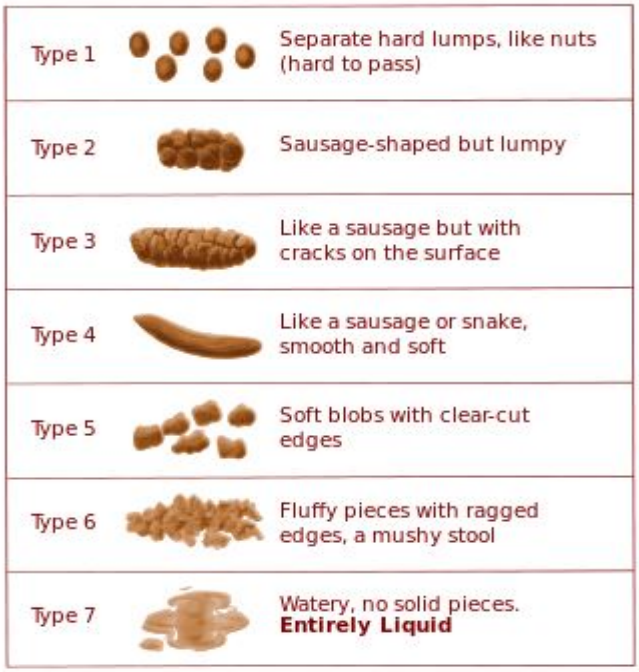
Joint , muscles
_____Joint pain/aches
_____Arthritis
_____Muscle stiffness
_____Muscle pain/aches
_____Weakness tiredness
Total _____

Digestion
_____Nausea, vomiting
_____Diarrhoea
_____constipation
_____bloating
_____belching, passing gas
_____heart burn, indigestion
_____intestinal pain or cramps
_____stomach pain or cramps
Total _____

Heart
_____Irregular heart beat
_____Rapid heart beat
_____Chest pain
Total _____.

How quickly do your symptoms appear after eating/drinking?
_____Immediately
_____A couple of minutes
_____A couple of hours
_____A couple of days

Bristol Stool Chart



Have you ever had food poisoning, and if yes, when, and where you picked it up traveling, home, from takeaway/eating out etc?_____

_____

_____

How did you treat it? Yourself, time, or with medication? If medication what and for how long did you stay on it? _____

_____

_____

Do you feel you have recovered, or is your body 'still not quite right'?_____

_____

_____

_____

Looking at the Bristol Stool chart, which type of poo do you usually pass? _____

If there are differences or a pattern, what is the difference/pattern?_____

_____

Do any of the following relate to your poo?

- ☐ Often float
- ☐ Medium brown
- ☐ Very dark brown/black
- ☐ Chalky
- ☐ Greenish
- ☐ Alternates between hard and loose
- ☐ Variable color
- ☐ Yellow, light brown
- ☐ Greasy/shiny
- ☐ Blood visible

This section is very important and you may be surprised what comes up for you. I ask you to think back as far as you can recall, childhood, and adolescence then to your current age. As you move through the ages, recall anything that impacts on your health. Things can include moving home, loss of a pet, family member or friend, change in school, moving out of home, illness; expectations from school, home, church, or significant others; stressors from things out of your control; own expectations around an event of situation; travel, especially to a different country, and you got ill while away or shortly after.

By asking yourself the following question can plant in the inquisitive mind to give you the answers we need. "What happened between the ages of _ and ___ that had a negative impact on my health and wellbeing, and "Has contributed to my current health concern?"

In a brainstorming manner write the various contributing factors to your current health concern:

_____

_____

_____

_____

_____

Now, go over the list again, and ask this question "Has this factor been resolved or is it still there?" Highlight the situation/s that still happening, knowingly or not; they are hiding in your body somewhere and possibly wanting to be addressed. _____

_____

_____

_____

_____

Patient Details_____Primary Start Date_____

Please record all food and drinks consumed for as many days as you can before your appointment include brand names. Please also indicate symptoms if any.

Day	Breakfast	Morning Tea	Lunch	Afternoon Tea	Dinner	Supper	Symptoms
1.							
2.							
3.							
4.							
5.							
6.							
7.							

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For the following foods, please tick any of the following you currently eat or drink more than once per week.

☐	Apples	☐	'Extra' Chewing Gum	☐	Baked Beans	☐	Sheep or Goat Milk	☐	Potato Chips
☐	Pears	☐	'Diet' Confectionary	☐	Chickpeas	☐	Hard Cheese	☐	Wheat bread
☐	Honey	☐	Onion	☐	Lentils	☐	Ricotta or Cottage Cheese	☐	Wheat Pasta
☐	Dried Fruit	☐	Leeks	☐	Legumes	☐	Yoghurt – Regular	☐	Wheat Biscuits
☐	Fruit Juice	☐	Garlic	☐	Tofu	☐	Yoghurt – Soy	☐	Wheat Muesli
☐	Canned Fruit	☐	Spring Onion	☐	Cow's Milk	☐	Ice-cream	☐	Gluten Free Bread
☐	Coconut milk/Cream	☐	Green Beans	☐	Lactose Free Milk	☐	Potato Crisps	☐	Wheat Free Rye Bread
☐	Peaches	☐	Cabbage	☐	Soy Milk	☐	Confectionery	☐	Wheat Free Muesli
☐	Apricots	☐	Nuts	☐	Rice Milk	☐	Chocolate	☐	Alcohol (specify) _____

Mark any that cause a reaction in your body.

Please list any foods, not listed you have already excluded due to you symptoms or problems they cause you:

_____

_____

_____

_____

Please write any questions you have for the dietitian to discuss during your appointment:

_____

_____

Patient Details_____Primary Start Date_____

Other notes or things you think of that have contributed to your current state of health and wellbeing