NUTRITION CLINIC
OF NORTHERN CALIFORNIA
Food & Nutrition Experts

Contact Information
History and Nutrition Assessment Forms

Welcome to our office and a new beginning!

"My goal as a Nutritionist in Private Practice is to inspire and empower patients to be as healthy as possible through the trans-formative powers of nutrition. I want to help people achieve and maintain an improved quality of life!"

Thank you for your interest in Nutrition Clinic of Northern California. Our health care team is committed to helping you change your nutritional lifestyle and travel a path of healthy living.

We strive to provide each person with the highest quality nutritional care in a gentle, caring and pleasant manner. It is our goal to help you enjoy the benefits of good health for the rest of your life… one bite at a time.

To make the first appointment as comfortable as possible, we kindly ask that you complete the enclosed forms along with the *Food Record* form prior to your initial visit.

It's important that you take the necessary time and answer each question to the best of your ability. The more we understand about your nutrition and health history, the better our team can help you with your nutritional goals. Please return the completed forms to our office either by fax or email.

If you have any questions, please call us and we will give you our immediate attention. We look forward to meeting you on your initial visit.

Wishing you the very best of health!

Sincerely,

Marie Tabatabaie, MS, Director
Nutrition Clinic of Northern California
Email: mt@nutritionworks4all.com
Website: www.nutritionworks4all.com

PATIENT INFORMATION		
Full Name:	**Date of Birth:**	**SSN (required for billing purposes):**
Mailing Address:	**City:** **State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Occupation:	**Email Address:**	
Height: **Weight:** **Age:**	**How did you hear about the Nutrition Clinic of Northern California?**	

PATIENT CONSENT & PRIVACY NOTICE

As a patient of Nutrition Clinic of Northern California, we respect the privacy of your protected health information and we will always take reasonable precautions to secure and protect that privacy.

Nutrition Clinic of Northern California requires your consent to use and disclose your protected health information to carry out treatment, payment, and healthcare operations. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of our Notice of Privacy Practices of Nutrition Clinic of Northern California may change from time to time. You can obtain a copy of our revised Notice of Privacy Practices by contacting our office. We will also post a copy of our current Notice of Privacy Practices in our office. You have the right to revoke this consent in writing and the revocation will be effective except to the extent Nutrition Clinic of Northern California has acted in reliance on your consent.

I have had an opportunity to discuss with the Nutritionist and/or with other office personnel, the nature and purpose of the nutrition counseling session(s). I understand the results are not guaranteed. I give Nutrition Clinic of Northern California permission to send a summary note to my physician or referring doctor of my consultation here. By signing below, you hereby consent to our use of your protected health information for treatment, payment and health care operations and acknowledge receipt of a copy of this Consent if requested.

Printed Name: _____

Signature: _____ **Date:** _____

MEDICAL HISTORY / REVIEW OF SYSTEMS

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Snoring
- ☐ Sleep apnea
- ☐ History of pneumonia
- ☐ Chronic bronchitis
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

Cardiovascular

- ☐ High blood pressure
- ☐ Heart disease/heart attack
- ☐ Congestive heart failure
- ☐ Ankle or feet swelling
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

Gastrointestinal

- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Heartburn/GERD
- ☐ Belching / bloating
- ☐ Ulcer disease
- ☐ Cramps
- ☐ Colitis
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Crohn's
- ☐ Diarrhea / loose stool
- ☐ Gallbladder disease / stones / bile
- ☐ Celiac disease
- ☐ IBS
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

Genitouinary

- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Recurrent urinary infections
- ☐ Kidney stones
- ☐ Infertility
- ☐ Sexual problems
- ☐ Abnormal menstrual period
- ☐ Enlarged prostate
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

Musculoskeletal

- ☐ Aching muscles/joints
- ☐ Arthritis
- ☐ Low back pain
- ☐ Vertebral disc problem
- ☐ Torn ligaments/muscle soreness
- ☐ Osteoporosis/Osteopenia
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

Endocrine

- ☐ Diabetes Mellitus
- ☐ Thyroid disease
- ☐ Elevated cholesterol
- ☐ Elevated triglycerides
- ☐ Gout
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

Skin

- ☐ Infection (boils, ulcers, etc.)
- ☐ Chronic rashes
- ☐ Bruises easily
- ☐ Excessive hair growth (females)
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

MEDICAL HISTORY / REVIEW OF SYSTEMS

Other

- ☐ Low energy level
- ☐ Depression, Bipolar, ADD
- ☐ Anxiety disorder, OCD
- ☐ Panic attacks
- ☐ Psychological/Psychiatric care
- ☐ History of child abuse/rape
- ☐ History of any physical violence
- ☐ History of cancer
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Headache
- ☐ Other _____
- ☐ Family _____
- ☐ Comments:

Do you have family history of the following? (check all that apply)

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid disease
- ☐ High blood cholesterol
- ☐ Obesity
- ☐ Heart disease
- ☐ Other _____

Preventative care screenings and diagnostic tests you have had (check all that apply)

- ☐ Sigmoidoscopy
- ☐ Bone density
- ☐ Prostate/Testicular exam
- ☐ Cardiac stress test
- ☐ Mammogram
- ☐ Heart disease

List history of surgeries: _____

List current medications and dosages: _____

List current vitamins/supplements: _____

Do you have any food allergies?

Do you smoke cigarettes? If yes, how many cigarettes per day?

Do you drink alcohol? If yes, how many drinks per day?

Average hours of sleep each night? Is your sleep restful?

WEIGHT & DIET HISTORY

Have you tried to lose weight before? _____ Yes _____ No

How many times? _____ Age of first attempt: _____ years old

What did you do? _____

Why did you go on that diet? _____

Have you ever used any of the following for weight control? If yes, please explain.

Commercial diet programs _____ Yes _____ No _____

Liquid diets _____ Yes _____ No _____

Fad diets _____ Yes _____ No _____

Prescription diet pills _____ Yes _____ No _____

Over-the-counter diet pills _____ Yes _____ No _____

Laxatives _____ Yes _____ No _____

Diuretics _____ Yes _____ No _____

Ipecac syrup _____ Yes _____ No _____

Vomiting _____ Yes _____ No _____

Self-designed program _____ Yes _____ No _____

Other _____

Do you experience periods during which you eat uncontrollably? _____ Yes _____ No

If yes, how often? _____

At what age did this begin? _____ years old

Is this followed by:

_____ Vomiting Age began: _____ How often? _____

_____ Laxative use Age began: _____ How often? _____

_____ Excessive exercising Age began: _____ How often? _____

_____ Self-harm Age began: _____ How often? _____

_____ Negative emotions Age began: _____ How often? _____

_____ Other (explain) _____

Have you ever been diagnosed with an eating disorder? _____ Yes _____ No

If yes, please explain: _____

WEIGHT & DIET HISTORY – CONTINUED

Are you currently or have you ever received treatment? _____ Yes _____ No

If yes, please explain: _____

Do you currently restrict food for weight control? _____ Yes _____ No

If yes, please explain: _____

EXERCISE HISTORY

Do you exercise? _____ Yes _____ No

List type, duration, frequency, and intensity of exercise activities: _____

_____

_____

Have you exercised in the past year? _____ Yes _____ No

List type, duration, frequency, and intensity of exercise activities: _____

_____

_____

Do you have any physical conditions that limit your ability to exercise? _____ Yes _____ No

Please specify: _____

FAMILY WEIGHT HISTORY

Are members of your family overweight? _____ Yes _____ No

Please explain: _____

Are members of your family underweight? _____ Yes _____ No

Please explain: _____

Does anyone in your family diet? _____ Yes _____ No

Please explain: _____

EATING HABITS

Do you skip meals? _____ Yes _____ No

How many days per week do you eat: _____ Breakfast _____ Lunch _____ Dinner

Do you snack? _____ Yes _____ No If so, when? _____

Do you buy or pack your lunch? _____ Buy _____ # days per week

_____ Pack _____ # days per week

Do you eat out? _____ Yes _____ No How many meals per week? _____

What restaurants do you usually choose?

1. _____ 3. _____

2. _____ 4. _____

Who usually prepares the food at home? _____

Do you know how to cook? _____ Yes _____ No

Who does the grocery shopping? _____

Do you read food labels? _____ Yes _____ No If yes, what do you look at on the label? _____

_____

_____ Yes _____ No Do the nutrition facts influence your decision to eat the food?

_____ Yes _____ No Do you eat standing up?

_____ Yes _____ No Do you eat in the car?

_____ Yes _____ No Do you eat while watching TV?

_____ Yes _____ No Do you eat while reading or on the computer?

_____ Yes _____ No Do you eat with others?

_____ Yes _____ No Do you eat fast?

_____ Yes _____ No Do you eat when bored?

_____ Yes _____ No Do you eat when stressed?

_____ Yes _____ No Do you eat when you are lonely?

_____ Yes _____ No Do you eat when you are not hungry?

_____ Yes _____ No Do you avoid certain foods? If yes, please specify: _____

What are your favorite foods? _____

_____

_____

EATING HABITS – CONTINUED

What foods do you crave? _____

_____

_____

What foods do you dislike? _____

_____

_____

How much water do you drink per day? _____

How much coffee and/or tea (types) do you drink per day? _____

How much soda (types) do you drink per day? _____

MALNUTRITION SYMPTON

Do you now or have you ever experienced any of the following (please check and add details to explain):

_____ Irregular menstrual periods _____

_____ Absent menstrual periods _____

_____ Cold intolerance _____

_____ Tingling sensation in hands or feet _____

_____ Headaches _____

_____ Lightheadedness / Dizziness _____

_____ Fainting _____

_____ Sleeping difficulties _____

_____ Skin changes _____

_____ Hair Loss _____

_____ Hair growth on face and/or chest _____

_____ Chest pains _____

_____ Rapid heart beat _____

_____ Shortness of breath _____

_____ Mood swings _____

_____ Episodes of crying for "no reason" _____

_____ Frequently thinking about food _____

_____ Confusion _____

_____ Difficulty concentrating _____

_____Anxiety, especially around food _____

_____ Less social interaction with family _____

_____ Frequently tired _____

_____ Memory problems _____

_____ Difficulty making decisions _____

_____ Problems with teeth _____

_____ Sore throat _____

_____ Swollen parotid glands _____

_____ Other (please explain) _____

GOALS & EXPECTATIONS

Do you want to change your eating habits? _____ Yes _____ No

Why? _____

_____

Reason for today's visit? _____

Do you have a goal weight? _____ Yes _____ No What is it? _____

On a scale of 1-10 (0 = no motivation and 10 = highly motivated), how ready are you to make the changes to reach your goals? _____

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VITAMIN DEFICIENCY SYMPTONS – Check Symptoms Last 6 Months

B Complex

- ☐ Dermatitis, rough skin
- ☐ Fatique, drowsiness
- ☐ High sweets or alcohol
- ☐ Irregular blood sugar
- ☐ Irritability

B1

- ☐ Nerve, fear, paranoia
- ☐ Frequent alcohol or sushi
- ☐ Low appetite, nausea
- ☐ Reflex loss, tingling limbs
- ☐ Wavering vision
- ☐ Weak muscles, enlarged heart

B2

- ☐ Cracked lip corners (Cheilosis)
- ☐ Allergies, chem sensitivities
- ☐ Bloodshot eyes, tearing
- ☐ Excess sunlight or computer
- ☐ Hypo or hyper thyroid
- ☐ Light sensitivity, large pores
- ☐ Sore mouth, purple tongue
- ☐ Tetracycline overuse
- ☐ Watery eyes, burning lids

B3

- ☐ Rough skin (Pellagra)
- ☐ Anxious, fearful
- ☐ Delusions, hallucinations
- ☐ Diarrhea, heartburn
- ☐ Disorientation
- ☐ Hi corn, millet or alcohol

B5

- ☐ Hi stress life
- ☐ Burning cramps, little bile
- ☐ Frequent infections
- ☐ Loss of coordination
- ☐ Weak adrenal glands

B6

- ☐ Anemia (microcytic)
- ☐ Acne, toxemia
- ☐ Carpel tunnel syndrome
- ☐ Chemical sensitivities
- ☐ Contraceptives, PMS
- ☐ Diabetic neuropathy
- ☐ Epilepsy, seizures
- ☐ Huntington's chorea
- ☐ Kidney disease or stones
- ☐ Medication reactions
- ☐ Parkinson's disease

BIOTIN

- ☐ Hair loss
- ☐ Muscle pain
- ☐ Nausea, pallor
- ☐ Scaly rash: skin or scalp

CHOLINE & INOSITOL

- ☐ Cirrhosis, fatty liver
- ☐ Depression, nervousness
- ☐ Fat intolerance
- ☐ Memory loss, confusion
- ☐ Neuromuscular disorders

B12 & FOLATE

- ☐ Poor appetite, weight loss
- ☐ Poor memory

B12

- ☐ Nerve damage
- ☐ Autism
- ☐ Hyperthyroid (high)
- ☐ Multiple sclerosis
- ☐ Neomycin, Dilantin
- ☐ Poor coordination
- ☐ Poor digestion
- ☐ Senile dementia
- ☐ Vegetarian diet
- ☐ Viral infections, shingles

FOL

- ☐ Cervical dysplasia or cancer
- ☐ Contraceptives
- ☐ Diarrhea, floating stools
- ☐ Sulfa drugs, barbituates

VITAMIN C

- ☐ Broken capillaries (scurvy)
- ☐ Allergies, infections
- ☐ Bleeding gums, gingivitis
- ☐ Bruising
- ☐ Fatigue, weakness
- ☐ Poor wound healing
- ☐ Skin wrinkling, aging
- ☐ Smoking, dilantin
- ☐ Weak muscles, joint pains

VITAMIN P

- ☐ Adrenal insufficiency
- ☐ Atherosclerosis
- ☐ Bruising, broken capillaries
- ☐ Disc or joint degeneration
- ☐ Wrinkling, collagen disorder

VITAMIN A

- ☐ Night-blindness
- ☐ Acne, rashes
- ☐ Antibiotics, cholestyramine
- ☐ Cataracts, glaucoma
- ☐ Conjunctivitis, dry eyes
- ☐ Cystic Fibrosis
- ☐ Dry skin, sunburn
- ☐ Hypothyroid (low)
- ☐ Infertility
- ☐ Respiratory infections

VITAMIN D

- ☐ Bowed legs (rickets)
- ☐ Cortisone, dilantin
- ☐ Fall-winter depression
- ☐ Bone pains, fractures
- ☐ Kidney disease
- ☐ Limited sunlight
- ☐ Osteoporosis, osteomalacia
- ☐ Psoriasis

VITAMIN E

- ☐ Blood clots, anemia
- ☐ Broken capillaries
- ☐ Brown age spots - skin
- ☐ Cystic fibrosis, infertility
- ☐ Dry itchy skin, sunburn
- ☐ Female – breast cysts
- ☐ Heart disease
- ☐ Muscle damage
- ☐ Peripheral neuropathy
- ☐ Respiratory infections

VITAMIN K

- ☐ Bleeding ulcers
- ☐ Bruising, nose bleeds
- ☐ Coumarin, Dilantin, antibiotics
- ☐ Liver or kidney disease

VITAMIN Q

- ☐ Gum disease
- ☐ Heart disease
- ☐ Poor immunity

LIPOIC

- ☐ Aging, wrinkles
- ☐ Atherosclerosis, stroke
- ☐ Cataracts, retinopathy
- ☐ Diabetes, hypoglycemia
- ☐ Heavy metal toxicity
- ☐ High cholesterol, high LDL
- ☐ High lactic acid
- ☐ Nerve or brain damage
- ☐ Poor muscle tone, fat deposits

MINERAL DEFICIENCY SYMPTONS – Check Symptoms Last 6 Months

B

- ☐ Low sex drive or hormones
- ☐ Osteoporosis, osteomalacia

Ca

- ☐ Brittle bones, nails, teeth
- ☐ Fear of impending doom
- ☐ Muscle cramps at night
- ☐ Osteoporosis, osteomalacia
- ☐ Soda, cortisone, dilantin

C1

- ☐ Poor meat digestion
- ☐ Poor growth & weight gain
- ☐ Child – speech delay

Cr

- ☐ Diabetes
- ☐ Hi cholesterol, Hi LDL
- ☐ Hi triglycerides
- ☐ Hypoglycemia

Cu

- ☐ Anemia (microcytic)
- ☐ Child – kinke hair syndrome
- ☐ Hi LDL cholesterol
- ☐ Poor immunity: colds, flu
- ☐ Skin depigmentation
- ☐ Bruising (collagen)

Fe

- ☐ Anemia (microcytic)
- ☐ Fatigue, weakness
- ☐ Pale lips, pallor of face
- ☐ Poor alertness or memory

I

- ☐ Hypothyroid
- ☐ Dry skin, dry thin hair
- ☐ High cholesterol
- ☐ Learning disabilities
- ☐ Overweight, puffy face

Li

- ☐ Hyperactivity
- ☐ Manic-depressive

Mg

- ☐ Constipation, hemorrhoids
- ☐ Chest pains, heart disease
- ☐ Hi blood pressure
- ☐ Mitral valve
- ☐ Insomnia, irritability
- ☐ Menstrual cramps
- ☐ Muscle spasms or twitching
- ☐ Sodas, alcohol, cortisone

P

- ☐ Stiff joints, fragile bones
- ☐ Weakness, malaise

Zn

- ☐ Acne, rashes, dry skin
- ☐ Angry, aggressive, hostile
- ☐ Anorexia, low appetite
- ☐ Diabetes, hypoglycemia
- ☐ Diuretics, contraceptives
- ☐ Hi alcohol, Hi sugar
- ☐ Learning disability
- ☐ Loss of taste & smell
- ☐ Macular degeneration
- ☐ Poor immunity: colds, flu
- ☐ Poor wound healing
- ☐ Rarely remember dreams
- ☐ White spots on nails
- ☐ Child – poor growth, short
- ☐ Teen: delayed puberty
- ☐ Male: prostatitis, sterility
- ☐ Male: low sex drive
- ☐ Male: impotence

SUPPLEMENTS

List Current Supplements

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MINERAL DEFICIENCY SYMPTONS – Check Symptoms Last 6 Months

BONES & TEETH
Arg, His, Lys, Orn, Pro, Thr

- ☐ Fractures
- ☐ Osteoporosis
- ☐ Poor bone growth
- ☐ Poor calcium absorption
- ☐ Poor dental enamel (Thr)

BLOOD
Ala, Cys, Gly, His, Ser, Trp

- ☐ Damaged RBC (Glut)
- ☐ Low creatine (Ser)
- ☐ Low hemoglobin (His, Gly)
- ☐ Poor iron absorption (Cys

BLOOD SUGAR
Ala, Glu, Leu

- ☐ Alcohol cravings (Glu)
- ☐ Diabetes (Leu)
- ☐ Fatigue (Asp, Met)
- ☐ Low blood sugar (Ala)
- ☐ Sugar cravings (Glu)

BRAIN
GABA, Glu, Phe, Taur, Trp, Tyr

- ☐ Anxiety (GABA)
- ☐ Depression (Phe, Trp, Tyr)
- ☐ Epilepsy (GABA, Taur)
- ☐ Excessive appetite (Phe, Tyr)
- ☐ Insomnia (Trp)
- ☐ Learning disability (Phe)
- ☐ Low thyroid (Tyr)
- ☐ Mental retardation (Glu)
- ☐ Poor memory (Glu, Phe)
- ☐ Schizophrenia (Phe, Glu)
- ☐ Senility (Glu)

CONNECTIVE TISSUE
Gly, Lys, Pro (Collagen-Elastin*)

- ☐ Blood vessel damage
- ☐ Cartilage damage
- ☐ Cornea aging or damage
- ☐ Cornea aging or damage

DIGESTIVE SYSTEM
Gly, Glu, His

- ☐ Hyper acidity (Gly)
- ☐ Irritated intestine (Glu)
- ☐ Peptic ulcer (His, Glu, Gly)

HEART
Carn, Glut, His, Trp

- ☐ Atherosclerosis (Carn, Glut)
- ☐ Hi blood pressure (Trp, His)
- ☐ Hi cholesterol (Trp)
- ☐ Hi triglycerides (Carn)
- ☐ Irregular heart beat (Taur)
- ☐ Overweight (Carn)

IMMUNITY
Arg, Cys, His, Lys, Orn

- ☐ Excess nasal mucus
- ☐ Herpes, other virus (Lys)
- ☐ Poor immunity
- ☐ Low white blood cells (Cys, His)

LIVER & GALL BLADDER
Arg, Cys, Glut, Gly, Met, Orn, Thr

- ☐ Alcoholism (Taur)
- ☐ Chemical sensitivity (Met)
- ☐ Fatty liver (Met, Thr)
- ☐ Gall bladder dis (Gly, Taur)
- ☐ Liver degeneration (Arg, Orn)
- ☐ Liver toxicity (Asp, Glut, Met)

MUSCLES
Ile, Leu, Val, (BCAA), Arg, Glu, Gly, Lys, Orn, Ser

- ☐ Muscular dystrophy (Glu)
- ☐ Poor muscle size and tone

NERVES
Asn, Ser

- ☐ Nerve damage

SEX GLANDS
Arg, Ala, Gly, Glu

- ☐ Low sperm (Arg)
- ☐ Prostatitis (Ala, Gly, Glu)

SKIN, HAIR & NAILS
Gly, Lys, Pro (Collagen-Elastin*), Arg, Cys, Leu, Met, Ser, Tyr

- ☐ Age spots (Cys)
- ☐ Dry unmoist skin (Ser)
- ☐ Poor skin pigmentation (Tyr)
- ☐ Poor wound healing (Arg, Leu, Cys)
- ☐ Wrinkling* (Cys, Gly, Lys, Pro)
- ☐ Breaking nails (Cys, Met)
- ☐ Hair loss, damage (Cys, Met)

FATTY ACIDS
Cholesterol

- ☐ Low cholesterol <150
- ☐ Nerve damage

Omega 3 (linolenic)

- ☐ High cholesterol
- ☐ High LDL, low HDL
- ☐ Atherosclerosis

Omega 6 (linolenic)

- ☐ Bleeding fingertips & palms
- ☐ Cracked dry skin
- ☐ Irregular menstruation
- ☐ PMS

Omega 9 (Phospholipids & Sphingolipids)

- ☐ Learning disorder
- ☐ Multiple sclerosis
- ☐ Nerve or brain damage

SACCHARIDES
Glucosamine & Chondroitin

- ☐ Blood vessel damage
- ☐ Bone osteoporosis
- ☐ Cartilage or tendon damage
- ☐ Intestinal permeability
- ☐ Joint pains or damage
- ☐ Mucous membrane dryness
- ☐ Skin dryness

SACCHARIDES
Fructooligosaccharides

- ☐ Cancer
- ☐ HIV
- ☐ Myocarditis, pericarditis
- ☐ Nephritis (kidneys)
- ☐ Peritonitis (abdominal lining)
- ☐ Pleuritis (chest cavity lining)
- ☐ Polmyositis-dermatomyositis
- ☐ Rheumatoid arthritis
- ☐ Scleroderma
- ☐ Sjogren's disease
- ☐ Systemic lupus

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COMPANY POLICY INFORMATION

Welcome to a healthy new beginning! Thank you for choosing the Nutrition Clinic of Northern California as your nutrition specialist.

We look forward to working with you in helping you to achieve the goals, which motivated you to find us. We are here to meet your needs and offer you the best nutrition care possible. Below you find information on our company policy.

Method of Payment
Nutrition Clinic of Northern California accepts cash and check payment at the time of service. Please make payment payable to Marie Tabaie. There are no refunds for services purchased. There is a $50 fee for any returned checks.

Cancellation Policy
At the Nutrition Clinic of Northern California, we respect and value your time greatly. In the same regard, we kindly ask for a 72 hour advanced notice of cancellation in order to best serve clients. By giving advance notice, we are able to offer other clients who are waiting for services your appointment slot. Clients who do not cancel appointments within 72 hours will be charged in full for the appointment.

Email Communication
I may choose to send emails to the Nutrition Clinic of Northern California for purposes of communicating about my treatment plan, scheduling appointments, or other matter. I also permit the Nutrition Clinic of Northern California to communicate with me by email. I understand that sometimes this may include discussions about my health condition, medical history, or treatment plan, or any other medical-related matter.

Thank you for your cooperation!

I have read, understand, and agree to the above information.

Printed Name: _____

Signature: _____ **Date:** _____