CLIENT INTAKE FORM

Name of Coach: **Stasia Petralia**

Coach Number: **51466**

updated 26th February 2021

Important Note: pregnant women, nursing mothers and patients with severe renal or hepatic insufficiency cannot participate in the metabolic balance® program.

A) Personal Information

Title – Mr/Mrs/Ms/Miss	Gender: ☐ Male ☐ Female	
First Name:	Age:	
Last Name:	Weight:	kg
Date of Birth (mm/dd/yyyy):	Desired Weight:	kg
Street:	Height:	cm
City/Postcode:	Waist (at naval):	cm
Home Phone:	Hips:	cm
Mobile Phone:	Upper Thigh:	cm
Email:	Emergency contact:	
Profession:	Emergency contact number:	

How did you find out about metabolic balance®?

B) Nutritional Information

I eat everything	☐			
I refuse to eat:	☐ Natural Yoghurt	☐ Milk	☐ Cheese	☐ Poultry
	☐ Mushrooms	☐ Meat	☐ Sprouts	☐ Legumes
	☐ Goat milk	☐ Fish	☐ Seafood	☐ Any Soy
	☐ Camel milk			

Other foods I refuse to eat:

C) Health Information – up to 5 medical conditions may be considered by the program

☐ Acidosis	☐ Gallbladder disorders / colic(current)
☐ Acne	☐ Gallstones still present
☐ Allergies	☐ Gastric complaints or disorders
☐ Allergy to chemical solvents	☐ Gout
☐ Allergy to citrus fruits	☐ Grain intolerance
☐ Allergy to eggs	☐ Graves Disease
☐ Allergy to fish	☐ Hashimotos/inflammatory thyroiditis
☐ Allergy to fruits with pips (apples, pears)	☐ Hay fever
☐ Allergy to fruits with stones	☐ History of breast cancer
☐ Allergy to gluten	☐ History of cancer
☐ Allergy to grass pollen	☐ Hypertension (high blood pressure)
☐ Allergy to iodine	☐ Hyperthyroidism (overactive thyroid)
☐ Allergy to milk (cow's milk)	☐ Hypotension (low blood pressure)
☐ Allergy to nickel	☐ Hypothyroidism (underactive thyroid)
☐ Allergy to nuts	☐ Iron deficiency anaemia
☐ Allergy to rye	☐ Irritable bowel syndrome (IBS)
☐ Allergy to seafood	☐ Joint pain
☐ Allergy to yeast	☐ Lactose intolerance (late onset)
☐ Ankylosing spondylitis	☐ Lactose intolerant
☐ Arteriosclerosis	☐ Liver/gallbladder problems
☐ Asthma	☐ Menopausal symptoms
☐ Cardiac insufficiency	☐ Migraine
☐ Cardiovascular disease	☐ Multiple sclerosis
☐ Cholecystectomy (gallbladder removed)	☐ Mycosis (candida or fungal infections
☐ Coeliac disease (medically diagnosed)	☐ Osteoporosis
☐ Crohn's disease – inflammatory bowel disease	☐ Polycystic ovarian syndrome (PCOS)
☐ Depression	☐ Psoriasis
☐ Diabetes Mellitus	☐ Rheumatoid Arthritis
☐ Digestive disorders	☐ Skin disorders
☐ Diverticulitis	☐ Sleep disturbances/Insomnia
☐ Eczema	☐ Thyroid dysfunction
☐ Endometriosis	☐ Ulcerative Colitis – IBD
☐ Favism (G6PD deficiency)	☐ Urolithiasis/urinary calculi or stones
☐ Flatulence	☐ Vertigo / dizziness

metabolic balance

D) Medication

I am not taking any prescribed medications ☐

I am taking	☐ Anticoagulants (warfarin)	☐ Diuretics
	☐ Blood pressure medication	☐ Gout/uric acid lowering medication
	☐ Cholesterol lowering/statins	☐ Hyperthyroid medication
	☐ Contraceptive pill/hormone medication	☐ Thyroxine
	☐ Diabetic medication	

Other prescribed medications:

E)   I would like to…

☐ Lose weight   ☐   Adjust my metabolism

☐ I hereby agree that my data will be stored and shared with the personnel and organization necessary for the plan creation according to the privacy practices described in the Notice of Privacy Practices. The lab results will be evaluated only for the creation of my nutritional plan and no medical evaluation will be performed.

☐ I am responsible for the cost of the blood tests and that in the rare event that the blood tests are grossly abnormal and metabolic balance® refuse to issue a plan, I am still liable for the costs of the blood tests.

☐ Metabolic Balance® is not looking after my medical care and I understand that Metabolic Balance® is associated with health benefits that may result in medication change. Clients who are on regular medication should consult their doctor before commencing metabolic balance®. Clients are responsible for informing their doctor of pathology results as appropriate.

☐ For sustained success, Metabolic Balance® requires a significant lifestyle change and commitment from the client. The degree of benefit is dependent on the level of my adherence to the plan.

Ensure a 12 hour fast before your blood draw – Drink only pure water!

Signature

Participant Name (please print clearly)   Date