CLIENT INTAKE FORM

Name_____ Phone_____ e-mail_____

Street Address_____ City_____ State_____ Zip _____

Date of Birth_____ Blood type_____ Age:_____ Referred by_____

Male ( ) Female ( ) Height_____ Weight_____ BMI_____ Hydration_____ Goal Weight_____

HEALTH OVERVIEW

◯ *Circle Current Problems* – (√) *Check Past Problems*

☐ Anemia	☐ Arthritis	☐ Cancer	☐ Blood Press (High / Low?)
☐ Chronic Fatigue	☐ Depression	☐ Acid Reflux	☐ Constipation
☐ Diabetes I or II	☐ Ulcers / Digestion	☐ PMS	☐ Bloating / Indigestion
☐ Thyroid	☐ Hypoglycemia	☐ Asthma	☐ Muscle spasms
☐ Skin problems	☐ Spine/Back/Neck	☐ Epilepsy	☐ Other (explain)_____
☐ Gall bladder	☐ Edema (fluid retention)	☐ Colon / IBS, etc	_____
☐ Liver	☐ Epstein Barr / Mono	☐ Insomnia	_____

1. Briefly outline your weight problems and what you have tried in the past:_____

_____

_____

1a. What is your lowest weight and at what age? _____ lbs at _____years old

1b. What is your highest weight and at what age? _____ lbs at _____years old

1c. How old were you when you began with weight challenges? _____ years old

1d. Have your weight challenges been _____ on-going? (or) _____ more intermittent?

2. List prescriptions and over the counter items taken at least once a month (HRT; anti-depressants; aspirin, sinus, Tums, etc)

_____

3. If under a physician's care, for what?_____

4. Occupation_____ 5. Job or career changes in the last 2 years? ☐ Yes ☐ No

6. Known Allergies? ☐ Yes ☐ No To which group? ☐ Medications ☐ Environmental ☐ Supplements ☐ Chemicals

☐ Animals ☐ Perfumes Other_____ 7. Average Stress Level 1 - 10?_____ If stress # is over 6, please explain:

_____

8. How many personal, unresolved issues do you think about on occasion? _____ (ie: job, friends, loss of loved one, etc)

9. Smoke? ☐ Yes ☐ No 10. If so, how many per day?_____ 11. # of teeth with <u>metal</u> fillings?_____ <u>(do not leave blank)</u>

12. # of root canals? _____ 13. # of capped or crowned teeth?_____ 14. Use recreational drugs? ☐ Yes ☐ No

15. Organs removed (include tonsils):_____

16. Do you drink Alcohol? ☐ Yes ☐ No 17. # of _____drinks per day / Week / Month (please circle one)

18. Total of caffeine drinks a day (coffee /cola)? _____cups 19. Do you eat chocolate more than 4 X's a week? ☐ Yes ☐ No

20. Ever lived within 10 miles of a chemical plant/paper plant or lived within 2 – 5 miles of electrical towers? ☐ Yes ☐ No

21. Exposure to chemicals, radiation, X-rays, insecticides, cleansers, etc.? ☐ Yes ☐ No / Any work related exposure? ☐ Yes ☐ No

If so, please list_____

22. Major injuries in your lifetime? ☐ Yes ☐ No If yes, please list the type of accident (auto, etc), year, area of body injured?

_____

23. Vigorous/ Cardiovascular exercise sessions per wk?_____ What type?_____

24. How many 8 oz glasses of water do you drink every day? _____ 25. What type do you drink?

Ionized ☐ Distilled ☐ Reverse Osmosis ☐ Tap ☐ Filtered ("Britta-type") ☐ Spring ☐ Bottled ☐

26. How often do your bowels move? _____ X's a day *(or)* _____ X's a week Ever too loose? ☐ Yes ☐ No

27. Circle items you eat: red meat / pork / turkey / chicken / eggs / fish / crackers / carbonated drinks / diet drinks / green tea / fruit / fried foods / milk / ice cream / cheeses / yogurt / Soy / coffee / processed meats / White or "enriched" bread / sprouted breads / beans / vegetables / salads / bottled salad dressing / powdered coffee creamer / cream /popcorn / canola oil / olive oil / sugar / honey / only organic foods / pasta / cookies / pretzels / peanuts / nuts / seeds / Equal sweetener / Splenda / Sweet n Low

Please list what foods and food - types that you generally eat at these meals: (***Please do not leave blank***)

28. Breakfast:_____Lunch:_____

Dinner:_____ Snacks_____

Desserts:_____ List any occasional cravings?_____

29. Do you take vitamins and / or herbs? ☐ Yes ☐ No

30. Any possibility of pregnancy? ☐ Yes ☐ No

CLIENT STATEMENT

I understand that I am here to learn about good health practices and may be offered information and education about the value of life-style changes as a guide to general-good health. Recommendations may include natural health practices; nutritional supplements; exercise; diets; educational classes; recommended reading; and/or personal follow-up sessions. This in no way obligates me to any recommendations, future visits and no guarantees have been promised to me. I understand that I am free to choose or not to choose to follow any recommendations that may be offered.

Signature	Date: