



Shape ReClaimed Intake Form

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you primarily:  Sit  Stand  Perform repetitive tasks

Are you:  Married  Single  Divorced  Widowed

Names and ages of children: \_\_\_\_\_

How did you hear about the SHAPE ReClaimed Program?

\_\_\_\_\_

What health benefits do you want to achieve with the SHAPE ReClaimed Program?

Lose weight  Increase energy  Improve sleep  Decrease inflammation  Improve eating habits

Increased stamina  Improve well-being  Other \_\_\_\_\_

Physical Health

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Are there any areas of your body that are not functioning optimally?  No  Yes

If yes, please explain: \_\_\_\_\_

Are you able to perform activities that are important to you?  No  Yes

If no, please explain: \_\_\_\_\_

On average, how many days/week do you exercise?  0  1  2  3  4  5  6  7

What forms of exercise do you perform? \_\_\_\_\_

Do you stretch regularly?  No  Yes

If yes, what forms for stretching do you perform? \_\_\_\_\_

On average, how many hours do you sleep/night?  <5  6  7  8  9  10+

Do you wake up feeling refreshed?  Always  Sometimes  Rarely  Never

Have you ever been hospitalized or had surgery?  No  Yes

If yes, why and when: \_\_\_\_\_

Have you been diagnosed with any clinical condition or disease?  No  Yes

If yes, what: \_\_\_\_\_

Have you ever been in a motor vehicle accident?  No  Yes

If yes, what kind and when: \_\_\_\_\_

Were you evaluated and treated after each accident?  No  Yes

Have you had any non-vehicle accidents or falls?  No  Yes

If yes, please explain: \_\_\_\_\_

Have you had any imaging performed in the last year?  No  X-ray  MRI  CT  US  PET

Have you had blood work performed in the last year?  No  Yes

Were your test results in medically normal ranges?  No  Yes

If no, which results were abnormal? \_\_\_\_\_

### ***Mental/Emotional Health***

Rate your current level of **personal stress** in your life:  None  Low  Moderate  High

Rate your current level of **relationship stress** in your life:  None  Low  Moderate  High

Rate your current level of **health stress** in your life:  None  Low  Moderate  High

Rate your current level of **family stress** in your life:  None  Low  Moderate  High

Rate your current level of **occupational stress** in your life:  None  Low  Moderate  High

How do you manage the stress in your life? \_\_\_\_\_

### ***Chemical Health***

Do you choose to get annual flu shots?  No  Yes

Have you used antibiotics in the last year?  No  Yes: \_\_\_\_\_

How many cups of water do you drink/day?  0  1-3  4-6  7-9  10+

How many cups of coffee/energy drinks do you drink/day?  0  1-3  4-6  7-9  10+

How many glasses of juice/soda/sports drinks do you drink/day?  0  1-3  4-6  7-9  10+

Do you eat wheat products (bread/pasta/crackers/baked goods)?  No  Yes

If yes, how many servings/day? \_\_\_\_\_

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Do you eat refined sugar?  No  Yes

If yes, how many servings/day? \_\_\_\_\_

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, Nutri-sweet, diet drinks)?  No  Yes

Do you have any food/drink allergies, sensitivities, or intolerances?  No  Yes: \_\_\_\_\_

Do you smoke?  No  Yes  I used to for: \_\_\_\_\_ years

Are you/have you been exposed to second hand smoke?  No  Yes

Do you take probiotics?  No  Yes

Do you take vitamin D?  No  Yes

Do you take Omega 3?  No  Yes

Other supplements or homeopathics: \_\_\_\_\_

Please list any medications that you take regularly and why: \_\_\_\_\_

## Food Health

Please list the foods you commonly eat for:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks \_\_\_\_\_

How many cups of vegetables do you eat/day?  0  1  2  3  4  5  6  7+

What foods do you crave? \_\_\_\_\_

Please state specifically what your goals are with this program: \_\_\_\_\_

I \_\_\_\_\_, hereby grant permission to receive a professional and complete physical examination and consultation, including an initial urine analysis and evaluation.

Patient's Signature

Date