Nutrient Therapy Intake Form

Patient Information

Today's Date_____

Name:_____

Address:_____

Phone: (H)_____ (C)_____

Date of Birth (MM/DD/YY)_____ Age_____ Sex M / F

Occupation:_____ Email Address:_____

In case of emergency, please contact: (Name & Phone)

How did you hear about us? Internet Facebook Walk-in Friend(name)_____

What are your main complaints? (Please circle all that apply)

Fatigue and low energy	Stress
Poor diet due to busy lifestyle	Brain Fog or trouble concentrating
Low mood or depression	Cold or flu like symptoms
Dull or dry skin	Malabsorption issues

Other_____

Which Statements best describe why you are here today? (Please check all that apply)

I want to have more energy and feel better overall
I want to do everything I can to nourish my body
I want to do everything I can to enhance my weight loss efforts
I want to prevent getting sick
I want to recover quicker from my surgery or illness
I want to slow the aging process
I want to feel and look younger
I want to have smoother, brighter and more vibrant skin
I want to cleanse my body of toxin
I want to recover quicker from a hangover
Other (list)_____

Medical History

Are you pregnant or breastfeeding? Yes / No

Date of LAST CHEMISTRY SCREEN OR OTHER LAB TESTING_____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

(Please circle all that apply)

Hypermagnesemia (High magnesium levels) Hypercalcemia (High calcium levels)

Hypokalemia (Low potassium levels) Hemochromatosis (High iron levels)

Other_____

Are you a diabetic? Yes / No

Are you a smoker? Yes / No If yes, how much do you smoke?_____

How many alcoholic drinks do you consume in a week? _____

Do you use recreational drugs? Yes / No If yes, which ones and how often?

_____

_____

_____

Please list everything you are currently taking (both prescription meds and over the counter drugs including strength, frequency and condition being treated)

_____

_____

_____

Please list vitamins and other supplements including strength, frequency and condition being treated:

_____

_____

_____

Medical History Continued

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If yes, please list _____

Do you take Steroids, i.e. Prednisone? Yes / No If yes, please list_____

Do you have any allergies to medications or food? Yes / No

If yes, please list_____

Do you have any of the following conditions (Please circle all that apply)

Blood pressure problems (high or low)	Heart Problems
Stroke or "mini-stroke"	Kidney problems
Kidney Stone	Asthma
Sickle Cell Anemia	G6PD Deficiency
Sarcoidosis	Parathyroid problems (High Levels)
Maple Syrup Urine Disease	Thomsen Disease
Hyperaldosteronism	

Please list any other medical conditions you have that are not mentioned above:

_____

_____

_____

Please list all surgical procedures you've had with approximate dates:

_____

_____

_____

Is there anything else you would like the physician or nurse to know?

_____

_____

_____