CLIENT INFORMATION

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Reason for visit (prioritized):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/Industry \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Movement / Exercise from Occupation: ­­­ ­­Lots of movement Some movement Very little movement

Stress Levels from Occupation:  High levels of stress  Moderate levels of stress  Low levels of stress

Nutritional data:

What type of diet do you follow? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many cups (8 oz. / half pint) of water do you drink per day? (Not as part of other drinks.) \_\_\_\_\_

What kind of water do you mostly drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many cups (8 oz. / half pint) of caffeinated coffee or tea do you drink per day? \_\_\_\_\_\_

How many cans (12 oz. or 3/4 pint) of soda do you drink per week? \_\_\_\_\_\_

How many cups (8 oz / half pint) of cow's milk do you drink per week? \_\_\_\_\_\_

How often do you drink alcohol (wine / beer / spirits)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times per day do you eat sugary foods, including sweet cereals, candies, desserts, etc.? \_\_\_\_\_

Do you usually try to avoid eating highly processed foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you usually try avoiding artificially flavored or colored foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you usually try to avoid artificial sweeteners? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you try to mostly consume organic foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you eat at restaurants? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate any known food allergies or sensitivities:

|  |  |
| --- | --- |
|  | Cow's Milk |
|  | Eggs |
|  | Tree Nuts |
|  | Peanuts |
|  | Shellfish |
|  | Wheat |
|  | Gluten |
|  | Soy |
|  | Fish |
|  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

If you eat breakfast, describe your typical breakfast foods. ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you eat lunch, describe your typical lunch foods. ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you eat dinner, describe your typical dinner foods. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you snack, describe your typical snack foods, including desserts. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Including both snacks and meals, how many times per day do you typically eat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of the following do you consume? (example: 1D = 1/day, 2W = 2/week, 3M = 3/month)

Fruit \_\_\_\_\_ Vegetables \_\_\_\_\_ Eggs \_\_\_\_\_ Dairy \_\_\_\_\_ Fermented food \_\_\_\_\_ Fast food \_\_\_\_\_

Chicken \_\_\_\_\_ Fish \_\_\_\_\_ Red Meat \_\_\_\_\_ Pork \_\_\_\_\_ Meat Alternatives \_\_\_\_\_

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

What foods do you dislike the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Timing:

What is the first thing you do when you get up in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you eat your first meal? \_\_\_\_\_\_\_\_\_\_\_\_ Last meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which meal is your largest of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe a typical largest meal. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Lifestyle:

Indicate which of the following apply to you.

|  |  |  |  |
| --- | --- | --- | --- |
|  | I live alone. |  |  |
|  | I am recently bereaved. |  |  |
|  | I am recently divorced or separated. |  |  |
|  | I have recently become a parent. |  |  |
|  | I am the main care provider in my family. |  |  |
|  | I work long or irregular work hours (including shift work). |  |  |
|  | I find it difficult to cope with my workload. |  |  |
|  | I feel supported by the people around me. |  |  |
|  | I feel guilty when I'm relaxing. |  |  |
|  | I spend a lot of time in front of a TV or computer. |  |  |
|  | I am often using a mobile phone or tablet.   |  |  | | --- | --- | |  | I am a frequent flyer. | |  | I use aluminum cookware or aluminum foil. | |  | I drink from plastic bottles or wrap food in plastic. | |  | I try to use natural and organic home cleaning products. | |  | I use aluminum-free antiperspirants. | |  | I use fluoride-free toothpaste. | |  | I choose personal care products and cosmetics that are free of toxins like BPA, parabens, phthalates, lead and more. | |  | I get regular vaccinations. | |  | I am highly sensitive to light, sound, or electromagnetic fields. | |  | I am highly sensitive to perfumes and other chemical products / smells. | |  | I feel ready to make a change.  What do you do to relax? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |

Movement:

Do you exercise/move/participate in fun sweaty activity? If so, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you look forward to it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel when you are finished? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep:

What time do you go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long do you sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake often? \_\_\_\_\_\_\_\_\_\_

If so, why and at what time(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel rested when you wake up for the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain when you first get up? \_\_\_\_\_\_\_\_\_\_ If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it go away upon moving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Matters:

On a scale of 1-10 with 10 being the highest possible and 1 being the lowest possible:

In a typical week, how would you rate your AVERAGE health levels (how well you are feeling)? ­­­\_\_\_\_

In a typical week, how would you rate your AVERAGE energy levels? \_\_\_\_

In a typical week, how would you rate your AVERAGE physical pain levels? \_\_\_\_

List your primary health concerns and how long ago they started. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any major life events and how long ago they occurred (e.g., loss of a loved one, a major or meaningful change of job or residence, accidents, childbirth, beginning or ending of important relationships), particularly anything that you feel may be relevant to your current health concerns.

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List any major health problems / hospitalizations from the past (including childhood) and how long ago they occurred. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate any of the following that you have been medically diagnosed with.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  | | --- | --- | |  | Autism | |  | Autoimmune Condition | |  | Bronchitis | |  | Cancer | |  | Celiac Disease | |  | Chronic Fatigue Syndrome | |  | Cirrhosis | |  | Coronary Artery Disease | |  | Crohn's Disease | |  | Cystic Fibrosis | |  | Diabetes Type 1 | |  | Diabetes Type 2 | |  | Epilepsy | |  | Endometriosis | |  | Fibromyalgia | |  | Gastroesophageal Reflux Disease (GERD) | |  | Gout | |  | Gum Disease | |  | Heart Disease | |  | Hemorrhoids | |  | Hepatitis A | |  | Hepatitis B  Hepatitis C |   Addison’s Disease | |  |  |  | | --- | --- | --- | |  |  | | |  | Huntington's Disease | | |  | Immune Deficiency | | |  | Kidney Disease | | |  | Learning Disorder | | |  | Liver Disease | | |  | Lupus  Lyme | | |  | Lymphedema | | |  | Meniere's Disease  Mold Toxicity | | |  | Multiple Sclerosis | | |  | Osteoarthritis | | |  | Osteoporosis | | |  | Pancreatitis | | |  | Parkinson’s Disease | | |  | Psoriasis | | |  | Raynaud's Disease | | |  | Rheumatoid Arthritis | | |  | Sinusitis | | |  | Sjogren’s Syndrome | | |  | Spleen Disorder / Removal | | |  | Stroke | | |  | Thyroid Disorder (Overactive or Underactive) | | |  | Vascular Disease  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |  | |  |

Indicate any of the following symptoms that you frequently or always have:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  | | --- | --- | |  | Acne | |  | Asthma | |  | Back Pain | |  | Bacterial or Viral Infections | |  | Bloating | |  | Chest Pain / Tightness | |  | Cold Hands / Feet | |  | Cold Sores | |  | Colds / Flu | |  | Constipation | |  | Coughing (Chronic) | |  | Dandruff | |  | Diarrhea | |  | Digestive Issues | |  | Dizziness / Vertigo | |  | Dry Mouth | |  | Ear Infections | |  | Eczema | |  | Eyes (Bloodshot) | |  | Eyes (Watery / Itchy) | |  | Fatigue | |  | Focus (Trouble Focusing / Concentrating) | |  | Fungal Infections | |  | Gums (Swollen / Bleeding) | |  | Hair Loss (Excessive) | |  | Hay Fever | | |  |  | | --- | --- | |  | Headaches | |  | Hearing Loss | |  | Rapid Heartbeat / Palpitations | |  | Heartburn | |  | High Blood Pressure | |  | Insomnia | |  | Joint Pain | |  | Memory Problems | |  | Muscle Pain | |  | Nasal Congestion | |  | Nasal Drip / Excessive Mucus | |  | Nausea / Vomiting | |  | Neck Pain  Nerve Pain  Numbness | |  | Physical Coordination Difficulties | |  | Shortness of Breath | |  | Skin Rashes | |  | Sore Throat | |  | Stuttering / Stammering | |  | Thirst (Excessive) | |  | Tinnitus (Ringing in Ears) | |  | Urination (Burning) | |  | Urination (Frequent or Urgent) | |  | Vision is Blurry (not corrected by glasses) | |  | Visual Impairment, Other | |  | Warts | |  | Wheezing | |  | None of These | |

Indicate any organs or parts of organs that have been removed.

|  |  |
| --- | --- |
|  | Appendix |
|  | Gallbladder |
|  | Kidney |
|  | Spleen |
|  | Stomach |
|  | Lung |
|  | Colon |
|  | Reproductive Organs |

Have you had an organ transplant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker or any other electrical device supporting your health? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dental:

Indicate which statements apply to you.

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| --- |
|  |
|  | I see the dentist regularly.  I have amalgam (aka "mercury") or gold fillings. |
|  | I have one or more root canals. |
|  | I have sore or bleeding gums. |
|  | I have loss of teeth / loose teeth. |
|  | I have an irregular bite, jaw tension; or I grind my teeth. |
|  | I have mouth ulcers. |
|  | I have receding gums. |
|  | None of these apply. |

Emotional:

On average, throughout a typical week, which of these would you consider to be the dominant or most common feeling that you're aware of?

Happiness/Joy

Sadness/Grief/Depression

Anger/Irritation

Anxiety/Fearfulness

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days in a typical week would you say you feel MOSTLY positive emotions?

I rarely or never feel MOSTLY positive emotions throughout the day

I feel MOSTLY positive emotions 1-2 days in a typical week

I feel MOSTLY positive emotions 3-4 days in a typical week

I feel MOSTLY positive emotions 5-7 days in a typical week

Eliminations:

Do you have daily bowel eliminations? \_\_\_\_\_\_\_\_\_\_ If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please describe your elimination pattern. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the most descriptive number(s) of your elimination(s) using the Bristol Stool chart provided. BSC # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A chart of different types of food

Description automatically generated

Females:

Are you post-menopausal? \_\_\_\_\_\_\_\_ If yes, at what age did you enter menopause? \_\_\_\_\_\_\_\_\_

What were the characteristics of your menopausal experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? \_\_\_\_\_

Are you now, or in the near future, planning to become pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your menstrual cycle regular? \_\_\_\_\_\_\_\_\_ Longer than 28 days? \_\_\_\_\_\_\_\_ Shorter? \_\_\_\_\_\_\_\_

Is your flow longer or shorter than 5 days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have cramps or clotting? \_\_\_\_\_\_\_\_ Would you describe the color of your menses as bright red, dark purple, or brown? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience PMS, cyclical headaches, or cravings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements/medications:

Do you take any supplements? \_\_\_\_\_\_\_\_ If so, what, how often and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any OTC medications routinely (such pain reliever or allergy medicine)? If so, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take prescription medications (prescribed by a licensed medical professional?) If so, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had strong reactions to any of the following? If yes, select all that apply.

Nutritional Supplements

Herbal Supplements

Prescribed Medications

Over-the-Counter Medications

Homeopathy

Energy Healing (e.g., Reiki)

Medical history:

Have you had any surgeries? If so, what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received any diagnoses from licensed medical professionals? If so, what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any pain or discomfort? If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Naturopathic history:

Have you ever been in consultation with a naturopath? If so, why? How long ago? \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was suggested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you experience a good outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you like about it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What wasn’t as successful for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have regular adjustments with a chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have regular body work/massages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all with which you are familiar:

Homeopathy

Bach Flowers/flower remedies

Probiotics

Aromatherapy

Muscle response testing

Herbals

Sports nutrition

Enzymes

**By submitting this intake form, you acknowledge that InTENNtional Wellness provides holistic wellness advice and guidance, not medical diagnoses or treatments. You agree to consult with your medical practitioner for any specific medical concerns or conditions.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**