YOU
Wellness Center

CLIENT INTAKE FORM

NAME DOB / / .

STREET CITY .

STATE ZIP PHONE .

EMAIL .

Marital Status S M D W LTR(COHABITATING) Children Y N # .

GENDER ASSIGNED AT BIRTH M F CURRENT .

PRONOUNS RACE .

HEIGHT WEIGHT BMI .

ANY CHRONIC ILLNESSES – N/A OR PLEASE LIST .

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MEDICATIONS /SUPPLEMENTS- .

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ANY DIET RESTRICTIONS OR RELIGIOUS CONSIDERATIONS Y N .

LIST IF ANY .

.

LIFESTYLE QUESTIONS

DO YOU SMOKE? Y N DO YOU USE ANY STREET DRUGS? Y N

DO YOU DRINK ALCOHOL? N Y DAILY SOCIALLY

DO YOU EXERCISE? Y N HOW OFTEN? .

TYPE OF EXERCISE .

DO YOU DRINK COFFEE? Y N TEA? Y N .

ARE YOU BASICALLY- SENDENTARY PHYSICAL .

ANY EXPOSURE TO TOXINS AT WORK? .

DO YOU HAVE ACCESS TO FOOD? Y N MEDICAL CARE? Y N .

DO YOU FEEL SAFE AT HOME? Y N .

GOALS:

WHAT BRINGS YOU HERE? WHAT CHANGES ARE YOU INTERESTED IN MAKING IN YOUR LIFE? DESCRIBE INCLUDING THINGS YOU HAVE TRIED THAT DIDN'T WORK