radiance from within
WELLNESS

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CHIROPRACTIC

CLIENT INTAKE FORM

Please fill out this form as honestly, fully and completely as possible and bring with you to your scheduled appointment.

Name			
Address			
City		Zip	
Phone		Email	
Occupation		Hours per week	
DOB		Gender	
Relationship Status			
Referred by			

HEALTH GOALS

What are your top 3 goals for your health and wellness? Please be specific.

What do you want to achieve during your initial visit?

If you had to achieve only one health goal in the next 3 months, what would you like to see change?

What is/are your biggest challenges reaching your nutrition goals?

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following: To improve your health, how ready/willing are you to...

	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day (food journaling) for 3-5 days.					
Make modifications to your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques consistently					
Engage in regular exercise/physical activity (3-5 days a week)					

What have you tried in the past to achieve your health goals? This includes any diet or fitness program, coaches, supplements, books etc.

Have you ever seen a Naturopath or Holistic Practitioner in the past? If yes, when and why?

Do you have any barriers that may impact your ability to follow a nutrition plan (e.g. significant financial constraints, time constraints etc)?

MEDICAL HISTORY

Please indicate whether you or any relatives have been diagnosed with any medical condition. *relatives include: Parents, Grandparents, Siblings.

Illness/Disease	Self: Age Diagnosed	Specify Family & Age Diagnosed	Describe

List all medications you are currently taking, along with the reason for use, and dosage:

Medication	Reason	Dosage/Duratiom

List any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages. Please include the brand:

Supplement	Reason	Dosage/Duration

List any known allergies (food, environmental, medications)

LIFESTYLE

What is your typical sleep schedule and how many hours of sleep do you get per night?

Do you have trouble: falling asleep? staying asleep? Yes/No/Occasionally

Do you awaken feeling rested? Yes/No

Do you experience any dups or highs in your energy levels throughout the day? If so, at what time of day?

Do you workout or participate in fun sweaty activity? How many times per week?

On a scale of 1 (extremely low) to 10 (extremely high), how would you describe your:

Stress Levels_____ Fulfillment _____
Energy Levels_____ Contentment_____
Happiness_____

What are the major causes or factors of your stress?

How does your stress manifest itself? (i.e. fatigue, irritability, anxiety, panic attacks?)

What coping mechanisms do you use?

Has there been any significant emotional trauma in your life (divorce, loss of a loved one, accident, abuse)? Please describe.

What do you think and feel about your body?Please explain emotionally/physically.

Do you vacation or take respite time taregularly? Yes/No.

Do you have any hobbies or activities you enjoy doing regularly?

Do you consume alcohol or tobacco?If so, how much?

How many hours do you spend daily on average:

On the Cellphone _____
Watching television _____
Reading _____
In front of computer _____

DIGESTIVE HISTORY

Do you associate any digestive symptoms with eating certain foods? Please explain.

How often do you have a bowel movement?

If you take laxatives, what type/brand and how often?

Would you describe your stools are hard, soft, or loose? (circle one)

Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often.	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

REPRODUCTIVE HEALTH (FEMALES ONLY)

Do you have any hormonal issues that you know of? Please explain if so:

Please circle any symptoms of PMS you experience:

Cramping	Mood changes	Cravings
Bloating	Breast tenderness	
Headaches	Irritability	

Please circle any symptoms of Menopause you experience:

Hot Flashes	Hot Headaches
Cravings	Irritability
Mood Changes	Weight gain

Do you experience emotional upset consistently every month? If so, please describe (anxiety, depression, etc):

How often do you have a menstrual cycle?

Have you noticed any changes in your menstrual cycle, for example, in the frequency, duration, flow, clotting, etc.? Please specify:

Are you on birth control? If yes, for how long and what reasons?

Are you using hormone replacement? If so, synthetic or natural, what type, and for how long?

Have you given birth? If yes, how many times?

Have you had a miscarriage?

Have you had any fertility treatments? If yes, please describe:

Could you be pregnant?Yes/No

DIET HISTORY

Do you have diet restrictions or limitations for any reason (health, cultural, religious, or other)? Please list any food allergies, sensitivities, or intolerances.

Are you currently on a special diet? Ie. Low-carb, gluten-free, FODMAP, Paleo etc

Who prepares the majority of your meals? If you do, how much time do you spend cooking/preparing meals each day?

Do you find cooking difficult?Please explain.

Which meals do you eat regularly, check all that apply:

- [ ] Breakfast
- [ ] Lunch
- [ ] Dinner
- [ ] Snacks

Do you experience any symptoms if meals are missed? Explain.

Please indicate the beverages you drink, and how often you drink them.

	Daily Amount
Water	
Tea: What type?	
Coffee	
Milk Alternative: Type_____	
Soda: Regular or Diet	
Alcohol: Wine/Beer/Liquor	
Other _____	

The nutrition/eating habits that are most challenging for me:

The nutrition/eating habits that I am most pleased with:

List any food cravings you may have.

Do you avoid or dislike certain foods? If so, why?

What foods do you eat most often (list top five):

Are there any foods you are not willing to give up?

Describe your relationship with food (excellent, good, poor, food is your enemy). Be specific.

Eating Style: Based on how you eat on a regular basis, please check all that apply:

- [ ] Fast eater
- [ ] Erratic eater
- [ ] Emotional eater
- [ ] Late night-eater
- [ ] Time constraints
- [ ] Dislike "healthy" food
- [ ] Travel frequently
- [ ] Do not plan
- [ ] Meals/menus
- [ ] Rely on convenience
- [ ] Family Members have different tastes
- [ ] Love to eat
- [ ] Eat too much
- [ ] Eat because I have to
- [ ] Negative relationship with food
- [ ] Struggle with eating issues
- [ ] Confused about food/nutrition
- [ ] Frequently eat fast food
- [ ] Poor snack choices

Additional questions/concerns or information I would like to share.

CONFIDENTIALITY AGREEMENT & INFORMED CONSENT

I,_____, take full responsibility for my health, progress and healing on my suggested nutritionand supplementation plan. I acknowledge that changes in health take time and I am ready for a plan that is not about quick fixes but rather about smaller changes over a period of time that lead to sustainable change. All information shared within this professional relationship will be held in strict confidence. Information may be shared at the client's request with a medical doctor, naturopathic physician or any other healthcare practitioner the client deems to be appropriate.

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. Any activity or program may have inherent risks which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself.

You agree to inquire about any activities or suggestions with which you are not familiar, and provide any information which may limit your participation in suggested activities. Results and changes in your general health and wellness may vary depending on medical conditions, medications, and accuracy in following suggested guidelines. Never reduce or eliminate physician prescribed medications without the direction of a medical care provider.

Date: _____

Signature: _____

Name: _____
(please print)

Date: _____