



Busy Women Wellness, LLC  
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**Confidential**

## **Intake Form**

Client Name			Date
Address: City	State	Zip	
Phone Number:	Email Address		
Date of Birth:	Height	Weight	

### **What do you need the most help with? (Please check all that apply)**

- Weight Loss
- Lack of Energy
- Support on What to Eat
- Skin Problems
- Emotional Eating
- Anxiety/Stress
- Sugar Addiction
- Other (Elaborate) \_\_\_\_\_

### **What have you done in the past to lose weight or address the above mentioned issue?**

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### **If you contacted me for support with weight loss, what is your desired weight? What are you exactly struggling with?**

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### **What are some of your top goals you would like to achieve?**

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### **Please list current medications and supplements, and why?**

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**Please list childhood illnesses**

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**Please list any illnesses in your family's medical history**

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**Please list any known allergies and sensitivities**

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**Please elaborate on your quality of sleep**

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**Bowel Movements, including the number of movements a day and consistency**

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**How often do you exercise, and for how long? What exercise do you like?**

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**Do you smoke regularly? How many per day?**

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**Do you regularly drink more than one alcoholic beverage? How many per day?**

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**Please list any additional comments and/or questions regarding your health and well-being**

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