Client Intake Questionnaire

Please complete it thoroughly and honestly. This helps me provide the best care possible.

Name: _____
Date of Birth: _____
Phone Number: _____
Email: _____

Medical History

Personal Medical History

Please list any past or current medical conditions, diagnoses, surgeries, or injuries you have experienced, along with approximate dates if possible. Include any medications or supplements you are currently taking.

Family Medical History

Please describe any significant health conditions that run in your family (such as heart disease, diabetes, high blood pressure, thyroid disorders, autoimmune conditions, etc.). Include which family members were affected if known.

Current Life Scheduled

1. What is your current daily schedule?

2. What is your career/ job? How many hours do you work? How active are you daily (outside of any exercising)?

General Health Overview

1. What are your primary health concerns?
(Please list symptoms, diagnoses, or areas you'd like to address)

2. When did these concerns begin?

3. What makes your symptoms worse or better?

4. What treatments, supplements, or therapies have you tried in the past (if any)?

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5. Are you currently under the care of a doctor or therapist? If so, for what?

Lifestyle

6. How would you describe your typical diet? (Include meals, drinks, and snacks)

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7. Do you currently take supplements or herbs?

___ Yes

___ No

If yes, please list:

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8. How often do you exercise? What type?

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9. How would you rate your energy levels?

___ Very Low

___ Low

___ Moderate

___ High

10. How many hours do you sleep each night? _____ hours

___ Restful

___ Trouble falling asleep

___ Wake often

___ Wake tired

Emotional/Mental Wellness

11. Do you experience anxiety, depression, or high stress levels?
___ Yes

___ No
If yes, please describe:

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12. Any major life events or traumas that may impact your health?

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13. Important Demographic Information

To help me better understand your background and provide care that is culturally sensitive and tailored to your needs, please answer the following. All questions are optional, and you may skip any you prefer not to answer.

- **Gender Identity:**
- **Sex Assigned at Birth:**
- **Race:**
- **Ethnicity:**

14. In the clearest way possible please detail your Holistic Health Goal:

In at least one sentence, please describe the specific health and wellness goals you would like me to help you achieve, considering any physical, emotional, mental, or spiritual areas important to you.

Additional Information

15. Please share anything else you think is important (lifestyle, relationships, career, spiritual life, etc.):

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16. Are you submitting any lab results for analysis?

___ Yes

___ No
If yes, please include the number of tests and what they are.

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17. Upload photos (if applicable):
(For skin conditions, rashes, swelling, etc.)

Filling this out thoroughly allows me to better assist you.

Thank you,
Dr. Shanice Bennett

Client Consultation Agreement (Contract)

For Holistic & Functional Wellness Services

Client Name: _____
Date of Agreement: _____

This agreement is entered into between Dr. Shanice Bennett ("Practitioner") and the client (“Client") for holistic consultation services. By signing this agreement, the Client affirms understanding and acceptance of the following terms:

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1. Nature of Services

Dr. Bennett is a Holistic Functional Medicine Practitioner providing non-medical, educational, and lifestyle-based wellness consultations. These services are **not intended to diagnose, treat, or cure medical conditions** and are not a substitute for medical advice from a licensed physician.

The recommendations provided may include—but are not limited to—nutritional guidance, herbal supplements, lifestyle modifications, and functional testing suggestions.

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2. Client Responsibility

The Client acknowledges:

- They are responsible for their own health and well-being.
- They will disclose full and accurate health information in all forms and communication.
- They will consult a medical doctor before beginning any new wellness or supplement plan if under medical care.

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3. Payment and Refunds

- **All services are paid in full at the time of booking.**
- **All sales are final.** Services are **non-refundable**, including for missed appointments, late cancellations, or dissatisfaction with outcomes.

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4. Scope of Services

- Clients will not receive immediate diagnoses or treatments.
- All recommendations are tailored and may take time to develop.
- Practitioner's analysis may require up to 2–5 business days after any consultation.
- Services are intended to guide and support—not guarantee—a specific result.

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5. Confidentiality

All client information is kept strictly confidential and will not be shared without written consent, unless required by law.

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6. Consultation Format

The client understands that:

- Email consultations allow for more thorough and flexible communication.
- Phone and video sessions include everything from the email consultation, with the addition of a scheduled appointment for 20 minutes to follow up.
- Practitioners reserve the right to determine if additional consultations are necessary to provide adequate recommendations.

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7. Legal Disclaimer

The Client understands Dr. Bennett is not acting as a licensed medical doctor. Services are not meant to replace conventional medical care. Any health changes are at the discretion and responsibility of the client.

By signing below, I acknowledge that I have read, understood, and agree to the above terms.

Client Signature: _____
Date: _____