Client Intake Questionnaire

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

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

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)?

---

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)

---

7. Do you currently take supplements or herbs?
☐ Yes ☐ No
If yes, please list:

8. How often do you exercise? What type?

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:

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

Additional Information

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

14. Are you submitting any lab results for analysis?
☐ Yes ☐ No
If yes, please include the number of tests and what they are.

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