INTEGRATIVE HEALTH PRACTITIONER

HEALTH INTAKE QUESTIONNAIRE

First Name	
Last Name	
Address	
City	
State	
Zip	
Email Address	
Phone Number	
Skype Name	
Birth Date	
Place of Birth	
Height	
Weight	
Gender	
Occupation	
Referred By	
Today's Date	
Describe Problem(s):	

What treatments have you tried?	
Has anything been successful?	
With whom do you live?	
Do you have any pets or farm animals? If yes, where do they live?	
Have you lived or traveled outside of the United States? If so, when and where?	
Have you or your family recently experienced any major life changes? If yes, please comment:	
Have you experienced any major losses in life? If so, please comment:	
How much time have you lost from work or school in the past year?	
Previous jobs:	
Did you feel safe growing up?	
Have you been involved in abusive relationships in your life?	
Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?	

Do you feel safe, respected and valued in your current relationship?	
Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?	
Would you feel safer discussing any of these issues privately? Would you prefer not to speak about these issues?	
List past Medical and Surgical History:	
List previous hospitalizations:	
How often have you taken antibiotics?	
How often have you have taken oral steroids?	
What medications are you taking now?	
List all vitamins, minerals, and other nutritional supplements that you are taking now.	
Were you a full term baby? A preemie? Breast-fed or Bottle-fed?	
As a child did you eat a lot of sugar and/or candy?	

INTEGRATIVE HEALTH PRACTITIONER

What is your typical daily diet:	
How much of the following do you consume each week?	Tea: Coffee: Soda: Other Caffeine: Dairy: Cheese: Bread: Sugar: Candy/Chocolate: Dessert:
Are you on a special diet?	
Is there anything special about your diet that we should know?	
Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? If yes, are these symptoms associated with any particular food or supplement(s)?	
Do you feel much worse when you eat certain foods?	
Do you feel much better when you eat certain foods?	
Does skipping a meal greatly affect your symptoms?	
Have you ever had a food that you craved or really "binged" on over a period of time?	

INTEGRATIVE HEALTH PRACTITIONER

Do you have an aversion to certain foods? If yes, what foods?	
How many bowel movements (BM) do you have per day?	
Do you have any constipation (straining or less than 1 BM/day) or diarrhea (loose stool)?	
Do you have intestinal gas? If so, when.	
How many times per week do you drink alcohol?	
Have you ever used recreational drugs?	
Have you ever used tobacco? (If so, for how long?)	
Are you exposed to secondhand smoke regularly?	
Do you have mercury amalgam fillings in your teeth? If so, how many?	
Do you have any artificial joints or implants? If so, which ones.	
Do you feel worse at certain times of the year?	
Have you, to your knowledge, been exposed to toxic metals in your job or at home?	

INTEGRATIVE HEALTH PRACTITIONER

Do odors affect you? If so, which ones?	
How would you rate your current level of stress?	
Have you ever had psychotherapy or counseling?	
Are you currently, or have you ever been, married?	
List your hobbies and leisure activities:	
Do you exercise regularly? If so, how many times a week?	
What type of exercise is it?	
Do your parents or siblings have (or had) any health issues? If so, please explain:	
[illegible]	

[illegible] on the path to taking your first step towards health and wellness!

I have read and understand everything on this page. I acknowledge Stephen Cabral and his associates are natural health practitioners and do not diagnose, cure, or treat any illness or disease. Further, the undersigned releases Stephen Cabral, his lab partners, his independent representatives, associates and affiliates from any and all liability for any failure to identify any medical condition or disease. It is understood and agreed that this is not the purpose of their natural health services.

Client Signature: _____ Date: _____