CLIENT INTAKE FORM

Name _____ Date _____ Male ☐ Female ☐

Address _____ City _____ State/Zip _____

Phone _____ Email _____ DOB _____

Weight _____ Height _____ Spouse Name & Contact _____

Employer/Positio _____
n

How did you learn about us? _____

Have you worked with a Naturopathic/Holistic Practitioner before? ☐ Yes ☐ No

Are you open to a new approach to health? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, how many times per week ? ____ How many hours? ____

Have you traveled outside of the US ☐ Yes ☐ No If yes, where? _____

**Please mark any of the following conditions you may currently have.

☐ Headaches	☐ Skin issues	☐ Fatigue/exhaustion
☐ Infection	☐ Cholesterol levels	☐ Joint or muscle concerns
☐ Menstrual concerns	☐ Dizziness/balance	☐ Poor sleep
☐ Hormonal changes	☐ Numbness in hand/feet	☐ Brain fog/forgetfulness
☐ Sinus congestion	☐ Bruises easily	☐ Menopausal symptoms
☐ Weight gain	☐ High Blood pressure	☐ Sugar/carb cravings
☐ Cold /Flu virus	☐ Constipation/Diarrhea	☐ Acid reflux
☐ Anxiety/Depression	☐ Acute/chronic pain	☐ Head trauma
☐ Allergies	☐ Irritaility	

☐ Others, please specify _____ _____ _____

List Diagnosis given by a physician?

List Medications	Why prescribed?	How long?

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Main Health Concerns To Address	Area of concern	How long?

How are these issues affecting your life now?

What will be your health in 5, 10 years from now if you do nothing?

When your symptoms are at its worst, how old do you feel?

At your current state, who does this affect & how?

What are you most worried about?

Any additional information?

How long are you ready to commit to adresing your health and feeling great again?

(1-2 months) ☐ (3 month) ☐ (6 month) ☐ (12 month) ☐

Term & Condition

I understand that Dr. Angela Rahm or any colleague associated with her is not diagnosing, treating, or claiming to cure any health concern you have listed on this form or has been discussed in email, conversation or otherwise. This is not a substitution for medical advice or treatment. All health concerns should be discussed with your primary medical provider. Any suggestions, recommendations or opinions are for educational purposes only and should not be considered medical advice.

Signature _____ Date_____