Client Intake Form

DR. Leslie KORN

Client Name _____ **Date** _____

Client Information

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Work _____

Cell _____

E-mail _____

Date of Birth _____ Gender:_____

Employer_____ _____Occupation_____

Marital Status: ☐ Single ☐ Married ☐ Partnership ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Partner Name _____# of Children _____

Emergency Contact _____

Contact Phone:

Home _____ Work _____ Cell _____

Primary Health Care Provider

Name _____

Address_____

City/State/Zip _____

Phone _____ Fax _____

I give my therapist permission to consult with my health care provider regarding my health and treatment.

Comments _____

Initials _____ Date _____

1. Current Health Information

Height _____Weight_____

List Health Concerns

Primary

☐ Mild ☐ Moderate ☐ Disabling ☐ Constant ☐ Intermittent

☐ Symptoms ↑ w/activity
☐ Symptoms ↓ w/activity
☐ Getting worse ☐ getting better ☐ no change

Treatment received

Secondary

☐ Mild ☐ Moderate ☐ Disabling ☐ Constant ☐ Intermittent
☐ Symptoms ↑ w/activity
☐ Symptoms ↓ w/activity
☐ Getting worse ☐ getting better ☐ no change

Treatment received

Have you ever received Energy Therapy before?
☐ Yes ☐ No Frequency? _____

Have you ever received Manual Therapy before?
☐ Yes ☐ No Frequency? _____

Have you ever received Psychotherapy before?
☐ Yes ☐ No Frequency? _____

What kinds of practitioners (formal/informal) have you worked with around food/diet/nutrition (example: Dietician, Health Coach, or Nutritional Therapist)?

List all conditions currently monitored by a Health Care Provider.

List Daily Activities

Work _____

Work Hours and Schedule _____

Do you now or have you ever worked the night shift? ☐ Yes ☐ No

If so, please explain _____

If currently, what are your hours? _____

Home/Family _____

Social/Recreational _____

Circle the above activities affected by your condition.

☐ all of the above

Check other activities affected:

☐ sleep ☐ washing ☐ dressing ☐ fitness

How do you reduce stress? _____

Pain? _____

What are your goals for receiving therapy? _____

2. Health History

List & include dates & treatments. Add pages if necessary.

Surgeries _____

_____

Accidents (physical-psychological) _____

_____

Major Illnesses _____

_____

Women

Last Pap _____ First day of last menstrual period _____

Marital/Partner History (Years Married) _____ Number of Children _____

Ages of Children _____ Number of pregnancies _____

Complications _____

Use of Contraceptive ☐ Yes ☐ No

What type? _____

Abortions/Miscarriages? _____

3. Lifestyle Factors

Exercise Activities

Please fill in the approximate amount for each type of exercise that you do. Include the amount of time spent (hours/minutes) and the frequency.

Type	Hours	Minutes	Never	0–1 times/week	1–2 times/week	3–5 times/week	Daily
E .g., Swim	1				X		
Bike							
Dance							
Garden							
Golf							
Hike							
Pilates							
Run							
Swim							
Tennis							
Ski							
Walk							
Weights							
Yoga							
Other: _____							
Other: _____							

4. Family Medical History

Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death.

Mother:

Father:

Siblings:

Mother's parents:

Father's parents:

5. Current Dietary Habits

Please list any specific diets that you are currently following, for example, vegan diet (no dairy, meat, fish or eggs), vegetarian, Atkins, paleo, DASH, raw, GAPS, etc:

Eating Behaviors: Briefly describe your mealtime and snack patterns:

Food Allergies and Sensitivities

☐ Wheat allergy ☐ Wheat sensitivity

☐ Dairy allergy ☐ Dairy sensitivity

Please list any other known or suspected food allergies and sensitivities: _____

Are there foods you could not give up? If so, which ones? _____

Current Food Preparation Methods

Who's doing the shopping? ☐ You ☐ Family member ☐ Friend ☐ Other

Do you eat with people or alone? ☐ People ☐ Alone

Do you eat out? ☐ Yes ☐ No

If so, how often? ☐ Once ☐ Monthly ☐ Twice monthly ☐ WeeklyDaily

What kinds of places do you eat out? _____

Do you prepare your own food? ☐ Yes ☐ No

Do you enjoy cooking? ☐ Yes ☐ No

How do you feel about food preparation and cooking? _____

_____

How much time do you spend preparing food each day? ☐ Never ☐ 1 hour ☐ 2 hours ☐ 3 hours

Food Symptoms

Please circle any of the following food symptoms that you experience on a regular basis:

☐ Stomachaches ☐ Burping ☐ Itching
☐ Sinus ☐ Flatulence ☐ Flushing
☐ Fatigue ☐ Bloating

6. Diet History

Were you breastfed, and if so, until what age? ☐ Yes ☐ No Until age:_____

Were you fed formula as a baby? ☐ Yes ☐ No

Did you experience ear infections as a child? ☐ Yes ☐ No

Use of antibiotics as a child/adult? ☐ Yes ☐ No

Please list any other childhood illnesses and the age at which they occurred: _____

_____

Please list any digestive complaints you recall having as a child (for example, stomach pains, diarrhea, constipation, gas, etc.) _____

_____

Please list any other physical complaints you recall as a child (for example, fatigue, headaches, pain):

_____

Acne as an adolescent? ☐ Nonex ☐ Mild ☐ Moderate ☐ Severe

History of fasting? ☐ Yes ☐ No

Did you experience any eating disorders during adolescence? ☐ Yes ☐ No

If so, please describe:

Briefly describe your family's eating habits and meal times (Did you eat as a family? Did you eat at the table or in front of the television? Did you fend for yourself? Were foods prepared from packages? Was there fighting at meal-time?):

7. Medications (Current and Past Use)

In the table below, please list any medications, including pharmaceuticals and antibiotics that you are currently or have previously taken.

Medication	Prescribed For	Dosage	Frequency	Dates/Duration
E.g., Wellbutrin	Depression	100mg	2/day	2010– present

8. Use of Non-Pharmaceutical Substances

Current	Past	Times per week / Comments
☐	☐	tobacco _____
☐	☐	alcohol/drugs _____
☐	☐	coffee/soda _____
☐	☐	other _____

Are you a recovering alcoholic? ☐ Yes ☐ No

History of drug or alcohol abuse? ☐ Yes ☐ No

Long term use of prescription/recreational drugs? ☐ Yes ☐ No

If yes, how often and in what form? _____

Do you use Nutrasweet (aspartame)? ☐ Yes ☐ No

9. Use of Nutritional Supplements / Herbs / Minerals

In the table below, please list any supplements, including vitamins, minerals, herbs, amino acids, and hormones that you are currently or have previously taken.

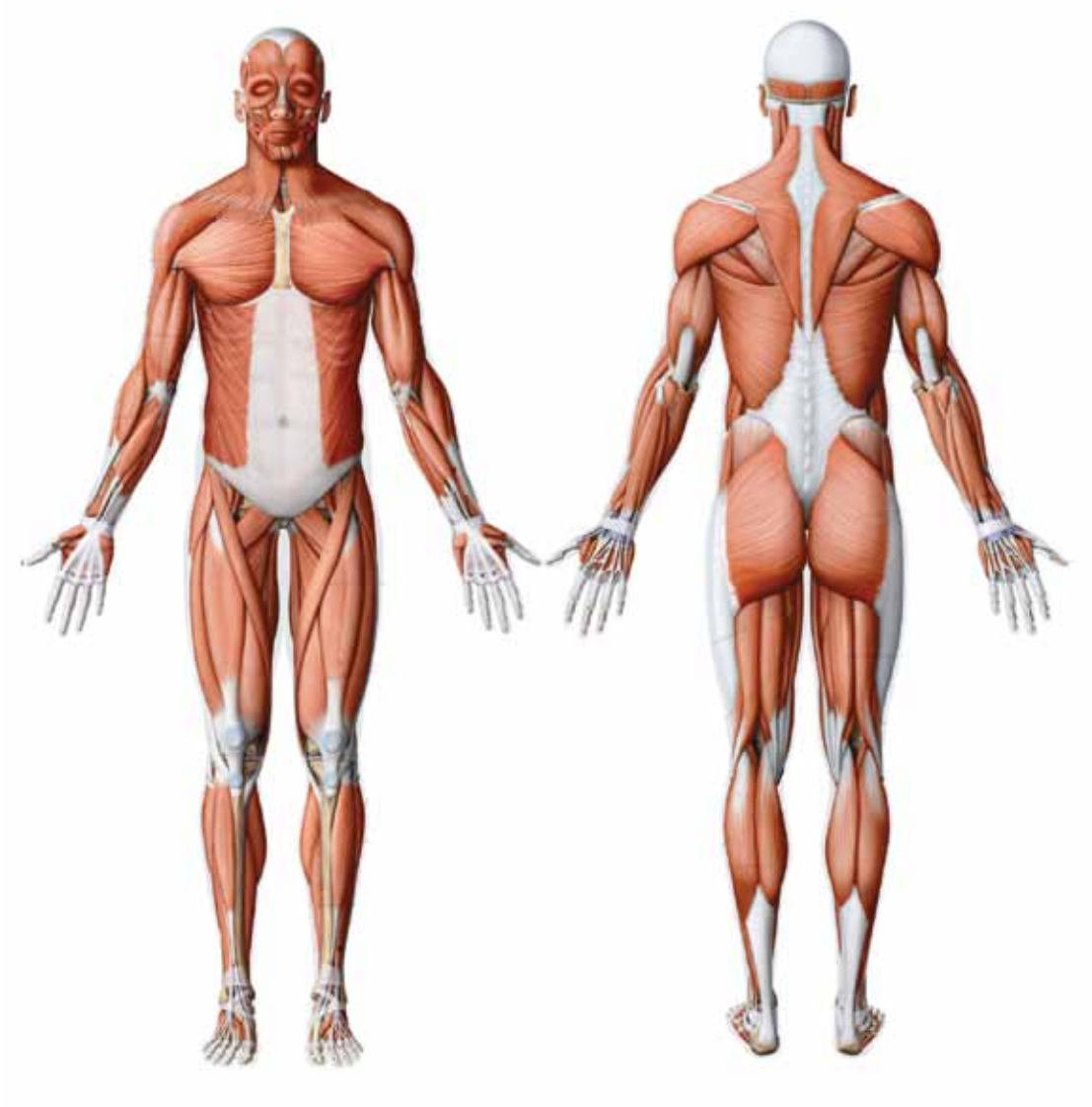
Supplements	Manufacturer	Dosage	Frequency	Dates/Duration
E.g., Vitamin C	Bronson	500mg	2/day	2012–4 months

10. Detoxification

If you are currently or have previously done any detoxification methods, please indicate which ones by filling in the table below. If you have done a detoxification method that is not listed in the table, write the name of it in the row marked "other."

Method	How Often	When	Dates/Duration	Desired/Perceived Benefits
E .g., Skin Brushing	1–2 times/ day	Before bathing	2013-present	Strengthen immunity
Skin Brushing				
Coffee Enema				
Liver Flush				
Juice Fast				
Colon Cleanser				
Epsom Salt Bath Soak (magnesium sulfate)				
Salt and Baking Soda Bath				
Vinegar Bath				
Sweats/ Saunas				
Castor Oil Packs				
Master Cleanse				
Other:				

11. Pain / Discomfort



Please describe the location and experience of pain:

Rate your stress level as of today

1 ——————————————————————— **10**

LOW **HIGH**

12. Check all Current and Previous Conditions (please explain)

General

CURRENT	PAST		Comments
☐	☐	headaches	
☐	☐	pain	
☐	☐	sleep disturbances	
☐	☐	fatigue	
☐	☐	infections in the ears	
☐	☐	fever	
☐	☐	sinus	
☐	☐	other	

Skin Conditions

C	P		Comments
☐	☐	rashes	
☐	☐	athelete's foot, warts	
☐	☐	other	

Allergies

C	P		Comments
☐	☐	scents, oils, lotions	
☐	☐	detergents	
☐	☐	other	

Muscles and Joints

C	P		Comments
☐	☐	rheumatoid arthritis	
☐	☐	osteoarthritis	
☐	☐	scoliosis	
☐	☐	broken bones	
☐	☐	spinal problems	
☐	☐	disk problems	
☐	☐	lupus	
☐	☐	TMJ, jaw pain	
☐	☐	spasms, cramps	
☐	☐	sprains, strains	
☐	☐	tendonitis, bursitis	
☐	☐	stiff or painful joints	
☐	☐	weak or sore muscles	
☐	☐	neck, shoulder, arm pain	
☐	☐	low back, hip, leg pain	

Nervous System

C	P		Comments
☐	☐	head injuries, concussions	
☐	☐	dizziness, ringing in the ears	
☐	☐	loss of memory, confusion	
☐	☐	numbness, tingling	
☐	☐	sciatica, shooting pain	
☐	☐	chronic pain	
☐	☐	depression	
☐	☐	other	

Respiratory, Cardiovascular

C	P		Comments
☐	☐	heart disease	
☐	☐	blood clots	
☐	☐	stroke	
☐	☐	lymphadema	
☐	☐	high, low blood pressure	
☐	☐	irregular heart beat	
☐	☐	poor circulation	
☐	☐	swollen ankles	
☐	☐	varicose veins	
☐	☐	pregnancy	
☐	☐	chest pain, shortness of breath	
☐	☐	asthma	
☐	☐	palpable heartbeat in abdomen	
☐	☐	other	

Digestive/Elimination System

C	P		Comments
☐	☐	bowel dysfunction	
☐	☐	gas, bloatingbladder/kidney dysfunction abdominal pain	
☐	☐	ulcers, colitis	
☐	☐	belching/gas within 1 hour after eating	
☐	☐	heartburn/acid reflux	
☐	☐	bloating within 1 hour after eating	
☐	☐	bad breath (halitosis)	
☐	☐	sweat has strong odor	

Digestive/Elimination System (Cont).

C	P		Comments
☐	☐	feel like skipping breakfast	
☐	☐	feel better if you don't eat	
☐	☐	sleepy after meals	
☐	☐	stomach pains/cramps	
☐	☐	diarrhea	
☐	☐	undigested food in stool	
☐	☐	pain between shoulder blades	
☐	☐	stomach upset by greasy foods	
☐	☐	nausea	
☐	☐	light or clay colored stools gallbladder attacks	
☐	☐	diarrhea	
☐	☐	undigested food in stool	
☐	☐	pain between shoulder blades	
☐	☐	stomach upset by greasy foods	
☐	☐	nausea	
☐	☐	light or clay colored stools	
☐	☐	gallbladder attacks	
☐	☐	gallbladder removed	
☐	☐	hemorrhoids or varicose veins	
☐	☐	chronic fatigue / fibromyalgia	
☐	☐	pulse speeds after eating	
☐	☐	airborne allergies, hives	
☐	☐	sinus congestion, "stuffy head"	
☐	☐	crave bread or noodles	
☐	☐	alternating cons-tipation/diarrhea crohn's disease	
☐	☐	asthma	
☐	☐	sinus infections	
☐	☐	use over-the-counter pain medications	
☐	☐	anus itches	
☐	☐	history of antibiotic use	
☐	☐	fungus or yeast infections	
☐	☐	irritable bowel/colitis	
☐	☐	other	

Endocrine System

C	P		Comments
☐	☐	thyroid dysfunction	
☐	☐	HIV/AIDS	
☐	☐	diabetes	
☐	☐	other	

Reproductive System

C	P		Comments
☐	☐	pregnancy	
☐	☐	reproductive problems	
☐	☐	painful, emotional menses	
☐	☐	fibrotic cysts	
☐	☐	Cancer/Tumors	
☐	☐	benign malignant	

13. Meaning of Food

Please describe in a few sentences what food means to you. There may be both positive and negative associations. There is no right or wrong to this answer. For example, is food important to you? Are you preoccupied with it? Does it feel nourishing? Does food cause fear or discomfort?

14. Motivation for Nutritional Change

Identify 3 reasons to improve your diet:

Identify 3 obstacles to improving your diet:

Identify 3 goals to improve your diet:

3 month goal	6 month goal	12 month goal

Identify 3 goals to improving your food preparation:

3 month goal	6 month goal	12 month goal

Food-Mood Diary and Clinician Checklist

Food/Mood Diary

Name: _____ Date: (dd/mm/yy)_____

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. Describe energy, mood or digestive responses associated with a meal/snack, and record it in the right-hand column. Use an up arrow (↑) for an increase in energy/mood, down arrow (↓) for a decrease in energy/mood, and an equal sign (=) if energy/mood is unchanged.

Time of waking:_____a.m. / p.m.

Meal	Beverages	Energy Level (↑, ↓, or =)	Mood (↑, ↓, or =)	Digestive Response (gas, bloating, gurgling, elimination, etc.)
Breakfast (Time:_____)				
Snacks (Time:_____)				
Lunch (Time:_____)				
Snacks (Time:_____)				
Dinner (Time:_____)				
Snacks (Time:_____)				

Clinician Checklist for the Food-Mood Diary

Question	Answer	Goals and Recommendations
1. How much time passed between when the client awakens and when they eat breakfast? Is the client eating breakfast?		One should always eat breakfast, containing at least 3–4 ounces of protein within 30 min-utes of waking for proper energy and blood sugar balancing.
2. How much water/broth is the client drinking throughout the day?		Water intake should be about 50 percent of body weight every day in ounces (example: if a person weighs 160 lb, they should be drinking 80 ounces of water daily).
3. How often is the client eating? How many hours between each meal or snack?		Food should be eaten every 3–4 hours to prevent mood swings, and the client should have at least 3 meals/day and 2 snacks.
4. How many servings of vegetables is the client eating per day?		At least 3 servings of vegetables should be eaten every day. A serving equals from ½ to 1 cup.
5. Is the client eating raw vegetables and fruits?		At least 1–3 servings of raw fruit or vegetables should be eaten every day.
6. Is the client eating enough protein? Note if lack of protein corresponds to drops in mood.		Proteins help to stabilize energy and balance mood and should be emphasized during the daytime hours.
7. Is the client eating enough fats? Note if lack of fats corresponds to mood shifts.		Fats help to stabilize energy and balance mood and should be emphasized during the daytime hours.
8. How many servings of starchy carbohy-drates is the client eating and at what times of day?		During the day carbohydrates are best when combined with protein, and carbohydrates should be emphasized in the evening for relaxation.
9. What is the quality of the food the client is eating (freshly prepared vs. canned or prepackaged foods)?		Recommend whole, fresh, organic foods over packaged and canned foods.
10. Is the client eating enough soluble fiber?		Soluble fiber is found in foods like oat bran, nuts, beans, lentils, psyllium husk, peas, chia seeds, barley, and some fruits and vegetables. Men should be eating about 38 grams/day, and women 25 grams/day.
11. Is the client eating enough insoluble fiber?		Insoluble fiber is found in wheat bran, corn, whole grains, oat bran, seeds and nuts, brown rice, flaxseed, and the skins of many fruits and vegetables.

Body/Pain/Visual Analog Scale

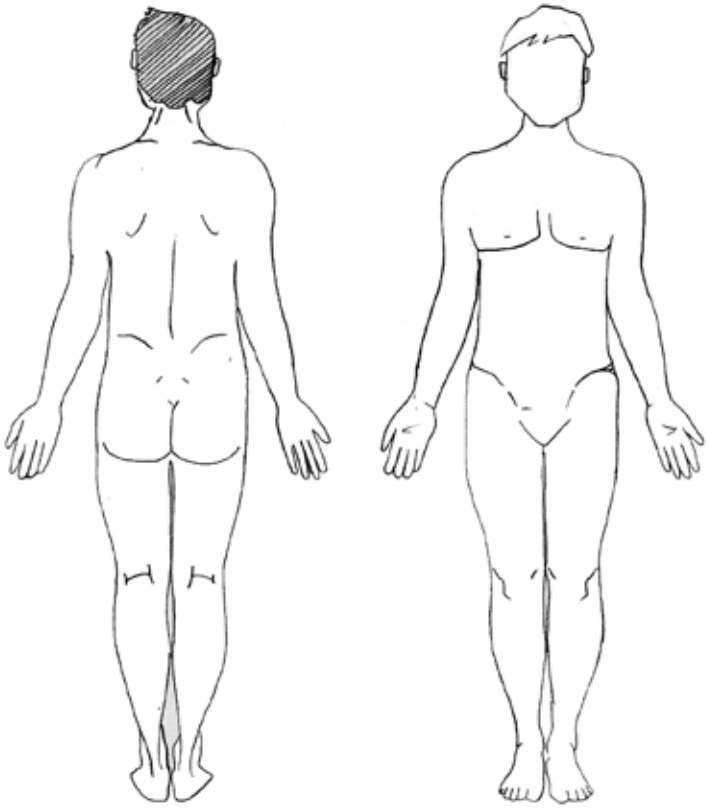
With a 0 to 10 scale, you rank how your pain feels from 0 (no pain at all) to 10 (the worst pain imaginable).

OR

With a visual analog scale, you mark where your pain falls on a line that runs from 0 (no pain) to 10 (the worst pain).

0 5 10

Check the areas of pain or discomfort on the figures below. Use the letters below to identify the type of sensation. Feel free to add any others you wish to.



A= Ache
B= Burning
M= Memory site
N= Numbness
P= Pins and Needles
S= Sharp/Stabbing
SC= Scar or surgeries
O= Other

Mindfulness with a Raisin

To enhance parasympathetic nervous system function and relaxation, I guide a client through a series of mindfulness exercises beginning in the office and asking them to complete the others at home and to share with other family members.

Hold a raisin and observe it as though you're the first person to ever touch a raisin and you're investigating for the first time. See the raisin in all of its detail; observe every part of it – the wrinkles, the way the light shines on it, etc. Touch the raisin and explore the texture and sensation. Smell the raisin and inhale its aroma; take note of how this fragrance may stimulate your stomach or mouth. Gently and slowly place the raisin in your mouth and before chewing; take time to notice how it feels on your tongue and any other sensations you notice. Prepare to chew the raisin by slowly finding out how to position it for chewing. Chew the raisin a couple of times and notice what happens when you do, really tasting it in all of its subtle complexities. Before swallowing, notice how the texture of the raisin changes as you chew it. When you're ready, think about swallowing the raisin and experience the intention of swallowing. Then swallow the raisin. Afterward, see if you can feel the raisin as it moves to your stomach. Observe how you feel after this exercise in mindful eating.