Intake Form

This form will help achieve your goals! Please take time to fill this out so I can learn more about you, and help you to the best of my ability.

Client Information

Name_____ Date _____

Address _____ City _____

State_____ Zip_____

Phone number (____) _____ Best time to contact _____

Birthday _____ Gender_____ Height_____ Weight_____ Nationality _____

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Referred By_____

Emergency Contact_____

Relationship_____

Why are you seeking help with your nutrition?

_____

_____

_____

_____

_____

Have you seen a doctor? _____

If so, what did they recommend?

_____

_____

_____

_____

What other therapies have you tried?

- ☐ Diet Modification
- ☐ Acupuncture
- ☐ Vitamins/Mineral Supplements
- ☐ Conventional Drugs
- ☐ Herbs
- ☐ Homeopathy
- ☐ Chiropractor
- ☐ Other _____

What helps you feel better? _____

What makes you feel worse? _____

Aewilliams201@gmail.com Amber E. Williams (785) 424- 3377

How long have you had this condition? _____

How does it affect daily life? _____

_____

Any other health concerns or goals?

_____

Personal Information/Lifestyle

Occupation _____ Normal work hours _____Is your job stressful? _____

How many hours/day do you spend:

- ❑ Working _____
- ❑ Driving _____
- ❑ Watching TV _____
- ❑ In front of computer/screen _____

On a scale 1-10 (10 highest), how stressed are you? _____

What causes your stress? _____

_____

How many hours of sleep do you get per night? _____

When do you go to bed? _____

Do you wake up feeling refreshed? _____

Do you wake up in the night? _____

Do you smoke? _____ Do you drink? _____

How much/how often? _____

Do you use recreational drugs? _____

What type? _____

Have you ever had a substance abuse problem? _____

Have you received treatment? _____

How often do you exercise? _____ How long? _____

What do you do for exercise? _____

_____

What is the most you have ever weighed? _____ When? _____

Medical History

How would you describe your general state of health? _____

Do You Wear:

- ☐ Corrective Lenses
- ☐ Dentures
- ☐ Hearing Aid
- ☐ Medical Devices/Prosthetics/Implants (List): _____

For the following tables, use the backside of this page if you need more room.

Please indicate any hospitalizations, surgeries, or injuries you have experienced:

Hospitalization/Surgery/Injury	Date	Symptoms	Was condition resolved?

Current medications/Supplements: List all you take on a regular basis:

Medication/ Supplement	Dose (if known)	Length of Use	Taken for?	Are you taking them presently?

Aewilliams201@gmail.com Amber E. Williams (785) 424- 3377

Allergies/Food Sensitivities:

Allergy/Sensitivity	Symptoms	Treatment

When Was Your Last Complete Physical Exam? _____

Have You Taken Antibiotics within the Last 5 Years? _____

How Many Times? _____

Were You Frequently Given Antibiotics as a Child? _____

How Often? _____

Have you ever been diagnosed with the following (Circle all that apply):

Alcoholism	**Crohn's Disease**	**Gastric/Duodenal Ulcer**	**Osteoarthritis**
Alzheimer's Diesease	**Depression**	**Head Injury**	**Osteoporosis**
Anemia	**Diabetes**	**Hepatitis**	**Pancreatitis**
Asthma	**Eating Disorder**	**High Blood Pressure**	**Pneumonia**
Bronchitis	**Emphysema**	**HIV**	**Rheumatoid Arthritis**
Cancer	**Endometriosis**	**Intestinal Parasites**	**Skin condition**
Cardiovascular Disease	**Epilepsy**	**Leaky Gut Syndrome**	**STD**
Celiac Disease	**Fibromyalgia**	**Mental Illness**	**Stroke**
Chronic Fatigue Syndrome	**Genetic Disorder**	**Migraine Headaches**	**Thyroid Condition**
Colitis	**Glaucoma**	**Mono**	**Other:**

Childhood History:

Were You Breastfed? _____ If Yes, How Long? _____

Were You Immunized? _____

If Yes, Did You Have Any Reactions? _____

Did you have any of the following "childhood" illnesses (Circle all that apply):

ADD/ADHD	**Eczema**	**Measles**	**Rheumatic Fever**
Frequent Ear Infections	**Meningitis**	**Thrush/Candida**	**Autism**
Chicken Pox	**Whooping Cough**	**Mumps**	**Asperger's**

Family History:

Has anyone in your family been diagnosed with any of the following? ("S"=Self, "F"=Father, "M"=Mother, "G"=Grandparent, "O"=Other; Include which of these behind each condition.)

Alcoholism	**Diabetes**	**Heart Disease**	**Multiple Sclerosis**
Alzheimer's Disease	**Drug Abuse**	**High Blood Cholesterol**	**Osteoporosis**
Asthma	**Eczema**	**High Blood Pressure**	**Osteoarthritis**
Cancer	**Epilepsy**	**Kidney Disease**	**Psoriasis**
Depression	**Fibromyalgia**	**Mental Illness**	**Thyroid Disorder**

List any other illnesses of relatives, such as parents, siblings, grandparents, aunts and uncles:

_____

_____

How often do you have bowel movements? _____

Do you strain to have a bowel movement? _____

- Related to any particular food or circumstance?

_____

When do you have loose bowel movements? _____

- Related to any particular food or circumstance?

_____

Females:

Are you pre-menopausal or menopausal? _____

Are you taking hormone replacement therapy? _____

List symptoms/concerns:

_____

_____

Number of pregnancies and age at each:

_____

_____

Natural deliveries? _____C-sections? _____

Are you currently tried to conceive? _____

Nutritional Habits

What time of day do you eat the following and give examples of each:

- Breakfast:

  _____

- Lunch:

  _____

- Dinner:

  _____

- Snacks:

  _____

Favorite foods:

_____

How often do you eat them?

_____

Do you avoid certain foods?

_____

- Why? _____

How do you feel after you eat?

_____

How do you feel after a missed meal?

_____

Do you eat on the go? _____ Are you an emotional eater? _____

Do you experience drops in energy? If yes, when? _____

Do you think you have regular eating habits? _____

Do you plan the frequency and timing of your meals? _____

Do you crave any of the following:

- ☐ Sugar
- ☐ Chocolate
- ☐ Salt
- ☐ Protein
- ☐ Fats
- ☐ Other: _____

Aewilliams201@gmail.com Amber E. Williams (785) 424- 3377

Are you on a special diet? If yes, why?

_____

Are you vegetarian or vegan? _____

If no, how often do you eat meat? _____

- What types?

_____

_____

How often do you consume dairy? _____

- What types?

_____

_____

How often do you consume vegetables? _____

- What types?

_____

_____

How often do you consume fruits? _____

- What types?

_____

_____

How often do you consume grains (refined/whole)? _____

- What types?

_____

_____

How often do you consumes fats? _____

- What types?

_____

_____

What fats/oils do you cook with (butter, olive oil, etc.)?

_____

How much water are you drinking on an average day? _____

Purified/filtered? _____

Do you drink coffee? _____

How many cups per day? _____

Do you drink caffeinated tea? _____

How many cups per day? _____

Do you drink soda? _____

How much per day? _____

- ❑ Regular
- ❑ Diet

Do you use artificial or sugar alternatives?

If yes, what kinds? _____

How often do you eat dessert? _____

What kinds? _____

Do you enjoy cooking? _____

- ➔ How many meals do you cook a week?

_____

Where do you buy your groceries? _____

- ❑ Organic
- ❑ Conventional

What is your favorite type of food? _____

What is your favorite restaurant? _____

What are healthy foods to you?

_____

_____

_____

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Health Objectives

If you change nothing about your lifestyle, where do you see yourself in 5 years?

Regarding food and lifestyle, are there any changes you have not made but believe you should?

Regarding food and lifestyle, is there anything you have tried to or believe you should avoid?

Are there any challenges you currently experience when making food and lifestyle changes?

Can you think of any challenges in the future that may discourage you from achieving your goals?

Aewilliams201@gmail.com Amber E. Williams (785) 424- 3377

Goals:

What do you want to achieve in..

- 3 months:

- 6 months:

- 1 year:

How will you know when you have achieved your goals?

Aewilliams201@gmail.com Amber E. Williams (785) 424- 3377

Level of Commitment for Lifestyle Changes

Please check the answer that you feel best fits with your current health goals.

Increasing daily water intake:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Adjusting eating habits:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Taking Supplements:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Lowering alcohol consumption:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Lowering soda intake:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Lowering coffee intake:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Quitting smoking:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Committing to exercise:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Making time to relax and reduce stress:
- ❑ Willing
- ❑ Maybe
- ❑ No way

Getting 8 hours of sleep a night
- ❑ Willing
- ❑ Maybe
- ❑ No way

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Level of Commitment for Lifestyle Changes

What are your expectations in working with me to achieve your health goals?

Is there anything that you would like to address that was not covered by this form?

Everything I have written and answered in this form is true to the best of my knowledge. I will update Amber Williams if anything changes. I understand and agree that this confidential information of my medical and health history will be maintained by my nutrition therapist and will not be released to any individual except when I have authorized this release in writing or when required by law.

Signature_____

Date_____

Aewilliams201@gmail.com Amber E. Williams (785) 424- 3377