

Client Intake Form

Please fill out the following questions as best you can. If there is a particular question you don't understand or want to fill out, we can discuss them at our first meeting. Thank you.

Name _____

Date _____

Phone (h) _____ (w) _____ (c) _____

Address _____

Email _____ Referred by _____

Personal Information

Birthday _____ Age _____ Height _____ Weight _____ Gender _____

Ethnicity _____ Marital Status _____ Children _____

Occupation _____ Hours in regular work week _____

What is the main reason for your visit?

Are you seeing any other health professionals at this time? Y N If yes, please list:

How well do you sleep? _____ Bedtime _____ Waking time _____

On a scale of 1-10 (10 being the highest) how would you rate your stress level? _____

What causes stress for you?

List any regular physical activities (frequency and duration):

List other hobbies or passions?

Do you smoke? Y N How much? _____

Do you drink alcohol? Y N How often? _____

Use recreational drugs? Y N Type/how often? _____

| Condition | Self | Mother | Father | Grand Parent | Condition | Self | Mother | Father | Grand Parent |
|---------------------|------|--------|--------|--------------|------------------|------|--------|--------|--------------|
| Heart Disease | | | | | Drug Abuse | | | | |
| Cancer | | | | | Alcohol Abuse | | | | |
| Autoimmune | | | | | Hepatitis | | | | |
| Allergies | | | | | Chronic Pain | | | | |
| Depression | | | | | Lungs/Chest | | | | |
| Arthritis | | | | | Skin | | | | |
| Diabetes | | | | | Gallbladder | | | | |
| HIV/AIDS | | | | | Reproductive | | | | |
| Thyroid Disorder | | | | | Stroke | | | | |
| High Blood Pressure | | | | | Osteoporosis | | | | |
| Migraines | | | | | Bone Fractures | | | | |
| PMS | | | | | Gastrointestinal | | | | |

Health History (please mark and X in the box for either yourself and/or family members)

Any other conditions not mentioned above? anemia, crohns, colitis, ulcers, chronic infection cold/flu:

How would you describe your overall health? _____

Last course of antibiotics? _____ What were they prescribed for? _____

Do you have any amalgam (silver) dental fillings? Y N How many? _____

Recent weight loss or weight gain? Y N If yes, how much? _____

Do you have any know allergens? Y N If yes, list allergy and symptoms:

Do you know your blood type? A B AB O

| Medications/Supplements | Dosage | Frequency |
|-------------------------|--------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Nutrition and Dietary Habits

How many meals do you typically eat per day? _____ Do you snack? _____

How many times a week do you:

Eat out at restaurants? _____ Eat breakfast? _____

Cook meals at home? _____ Grocery shop? _____

Do you normally eat alone or with friends/family? _____

Where do you grocery shop?

What is your weekly budget? _____ Do you read food labels? Y N

What is your favorite meal?

What are your favorite restaurants?

What 3 foods could you never give up?

What 3 foods do you refuse to eat?

How much water do you drink per day? _____ Foods you crave? _____

Do you drink coffee? Y N How much? _____ Sodas? Y N How much? _____

Do you have any food allergies? Y N Please list:

What are your allergy symptoms?

Have you tried any popular diets? Y N Which ones? _____

What was your experience?

What is your present diet: Vegetarian Vegan Gluten free
 Dairy free Kosher Other? _____

Are you pleased with your present diet? Y N What would you like to change?

Have you tried to make these changes? Y N

What influences your food choices:

Taste Nutrition Price Convenience Family Members Friends

How often do you have a bowel movement? _____ List any problems or issues?

Eating Patterns: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Eat too little | <input type="checkbox"/> Forget to eat |
| <input type="checkbox"/> Emotional eater | <input type="checkbox"/> Eat out of boredom | <input type="checkbox"/> Hungry all the time |
| <input type="checkbox"/> Late night snacking | <input type="checkbox"/> Fast eater | <input type="checkbox"/> Eat in the car |
| <input type="checkbox"/> Poor choices | <input type="checkbox"/> Healthy choices | <input type="checkbox"/> No joy in eating |

What do you consider healthy food choices?

What do you consider poor food choices?

How often do you eat the following foods in an average day/week?

| Food | Servings day/week | Food | Servings day/week | Food | Servings day/week |
|--------------|-------------------|--------------|-------------------|-----------------|-------------------|
| Fruits | | Pork | | Pasta | |
| Vegetables | | Nuts/Seeds | | Bread | |
| Whole Grains | | Dairy | | Fried Foods | |
| Red Meat | | Eggs | | Fast Food | |
| Poultry | | Soy Products | | Juice | |
| Seafood | | Legumes | | Desserts/Sweets | |

Women Only: Check those that apply.

- | | |
|--|--|
| <input type="checkbox"/> Perimenopausal | <input type="checkbox"/> Menopausal |
| <input type="checkbox"/> Regular periods | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Pregnant (how many months? _____) | |

Do you suffer from PMS? Y N If yes, please describe:

Are you taking any birth control? Y N If so, for how long _____

Are you taking any hormone replacement? Y N Please describe:

Please list any other additional information that you feel would be helpful: