KAISER PERMANENTE®

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)

- ☐ Eat too much
- ☐ Eat too little
- ☐ Forget to eat
- ☐ Emotional eater
- ☐ Eat out of boredom
- ☐ Hungry all the time
- ☐ Late night snacking
- ☐ Fast eater
- ☐ Eat in the car
- ☐ Poor choices
- ☐ Healthy choices
- ☐ 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.

- ☐ Perimenopausal
- ☐ Menopausal
- ☐ Regular periods
- ☐ Irregular periods
- ☐ 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: