# CLIENT INTAKE FORM

*Thank you for taking the time to fill out this form and provide the details of your health, goals and medical history.*

## CLIENT INFORMATION

Name_____

Address_____

City_____

State _____ Zip Code_____

Phone (day)_____

Phone (cell)_____

Phone (night)_____

Email_____

Referred by_____



 

**STATISTICS**

Age _____

Birth Date _____

Gender at birth _____ Chosen gender_____

Height _____

Blood type_____

Current weight _____

Ideal weight _____

Weight one year ago _____

Birth Weight (if known) _____

Birth Order (please list ages of biological siblings) _____

_____

Family/Living Situation _____

_____

Children: _____

_____

Occupation: _____

_____

Exercise/Recreation: _____

_____

**HISTORY**

1. Have you lived or traveled outside of the United States? If so, when and where?:

2. Have you or your family recently experienced any major life changes? If so, please comment:

3. How much time have you had to take off from work or school in the last year?

☐ 0 to 2 days

☐ 3 to 14 days

☐ more than 15 days

**STRESSFUL LIFE EVENTS**

*Studies show that past and continued trauma play a significant role in health and health outcomes. Our understanding of your history will help us to best support you moving forward.*

4. Have you experienced one or more of these stressful life events or traumas in your life?

Death of a family member, romantic partner or very close friend because of accident, homicide, or suicide ☐ yes ☐ no

Sexual or physical abuse by a family member, romantic partner, stranger, or someone else ☐ yes ☐ no

Emotional neglect or abuse such as ridicule, bullying, put-downs, being ignored or told you were no good by a family member or romantic partner ☐ yes ☐ no

Discrimination ☐ yes ☐ no

Life-threatening accident or situation (military combat or lived in a war zone) ☐ yes ☐ no

Life-threatening illness ☐ yes ☐ no

Physical force or weapon threatened or used against you in a robbery or mugging ☐ yes ☐ no

Witness the murder, serious injury or assault of another person ☐ yes ☐ no

5. Is there anything else that you'd like to share about these stressful life events or traumas?

**HEALTH CONCERNS**

6. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

7. When did you first experience these concerns?

8. How have you dealt with these concerns in the past?

☐ doctors

☐ self-care

9. Have you experienced any success with these approaches?

10. What other health practitioners are you currently seeing? List name, specialty and phone # below.

11. Please list the date and description of any surgical procedures you have had (including breast reduction or augmentation).

12. How often did you take antibiotics in infancy/childhood?

13. How often have you taken antibiotics as a teen?

14. How often have you taken antibiotics as an adult?

15. List any medicine you are currently taking:

16. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

17. Have any other family members had similar problems (describe)?

**NUTRITIONAL STATUS**

18. Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and the symptom:

19. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:

20. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

21. Are there foods that you crave? If so, please explain:

22. Describe your diet at the onset of your health concerns:

23. Do you have any known food allergies or sensitivities?

24. Which of the following foods do you consume regularly?

☐ soda
☐ diet soda
☐ refined sugar
☐ dairy (milk, cheese, yogurt)
☐ coffee
☐ alcohol
☐ fast food
☐ gluten (wheat, rye, barley)

25. Are you currently on a special diet?

☐ autoimmune paleo (AIP)
☐ SCD/GAPS
☐ dairy restricted or dairy-free
☐ vegetarian

☐ vegan
☐ paleo
☐ blood type
☐ raw
☐ refined sugar-free
☐ gluten-free
☐ ketogenic diet
☐ Other (please describe)

26. What percentage of your meals are home-cooked?

☐ 10 ☐ 30 ☐ 50 ☐ 70 ☐ 90
☐ 20 ☐ 40 ☐ 60 ☐ 80 ☐ 100

27. Is there anything else we should know about your current diet, history or relationship to food?

**INTESTINAL STATUS**

28. Bowel Movement Frequency

☐ 1–3 times per day
☐ more than 3 times per day
☐ not regularly every day

29. Bowel Movement Consistency

☐ soft & well formed
☐ often float
☐ difficult to pass
☐ diarrhea
☐ thin, long or narrow
☐ small and hard
☐ loose but not watery
☐ alternating between hard and loose

30. Bowel movement color

☐ medium brown
☐ very dark or black
☐ greenish
☐ blood is visible
☐ variable
☐ yellow, light brown
☐ chalky colored
☐ greasy, shiny

31. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

32. Have you ever had food poisoning? If yes, please describe in detail, including

1) Where were you?
2) What did you treat it with?
3) Do you feel like you fully recovered from it?

**MEDICAL STATUS**

33. Please identify any current or past conditions and add a date for when the condition appeared. In the space below each list, please briefly describe your symptoms, chosen treatment(s), and dates.

### Gastrointestinal

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Irritable Bowel Syndrome | ☐ | ☐ _____ | Gut infections |
| ☐ | ☐ _____ | Crohn's | ☐ | ☐ _____ | Dysbiosis |
| ☐ | ☐ _____ | Ulcertative Colitis | ☐ | ☐ _____ | Leaky gut |
| ☐ | ☐ _____ | Gastritis or Peptic Ulcer Disease | ☐ | ☐ _____ | Food allergies, intolerances or reactions |
| ☐ | ☐ _____ | GERD (reflux or heartburn) | ☐ | ☐ _____ | Gallstones |
| ☐ | ☐ _____ | Celiac Disease | ☐ | ☐ _____ | Known absorption or assimilation issues |
| ☐ | ☐ _____ | SIBO | ☐ | ☐ _____ | Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

### Cardiovascular

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Heart attack | ☐ | ☐ _____ | Elevated cholesterol |
| ☐ | ☐ _____ | Heart Disease | ☐ | ☐ _____ | Arrhythmia (irregular heartbeat) |
| ☐ | ☐ _____ | Stroke | | | |

| | | | |
|---|---|---|---|
| ☐ | ☐ _____ Hypertension (high blood pressure) | ☐ | ☐ _____ Mitral Valve Prolapse |
| ☐ | ☐ _____ Rheumatic Fever | ☐ | ☐ _____ Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Hormones/Metabolic**

| past | now date | past | now date |
|---|---|---|---|
| ☐ | ☐ _____ Type 1 Diabetes | ☐ | ☐ _____ Endocrine problems |
| ☐ | ☐ _____ Type 2 Diabetes | ☐ | ☐ _____ Polycystic Ovarian Syndrome (PCOS) |
| ☐ | ☐ _____ Hypoglycemia | | |
| ☐ | ☐ _____ Metabolic Syndrome | ☐ | ☐ _____ Infertility |
| ☐ | ☐ _____ Insulin Resistance or Pre-Diabetes | ☐ | ☐ _____ Weight gain |
| | | ☐ | ☐ _____ Weight loss |
| ☐ | ☐ _____ Hypothyroidism (low thyroid) | ☐ | ☐ _____ Frequent weight fluctuations |
| ☐ | ☐ _____ Hyperthyroidism (overactive thyroid) | ☐ | ☐ _____ Eating disorder |
| | | ☐ | ☐ _____ Menopause difficulties |
| ☐ | ☐ _____ Hashimoto's (autoimmune hypothyroid) | ☐ | ☐ _____ Hair loss |
| | | ☐ | ☐ _____ Other |
| ☐ | ☐ _____ Grave's Disease(autoimmune hyperthyroid) | | |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Cancer**

| past | now date | past | now date |
|---|---|---|---|
| ☐ | ☐ _____ Lung Cancer | ☐ | ☐ _____ Prostate Cancer |
| ☐ | ☐ _____ Breast Cancer | ☐ | ☐ _____ Skin Cancer (Melanoma) |
| ☐ | ☐ _____ Colon Cancer | ☐ | ☐ _____ Skin Cancer (Squamous, Basal) |
| ☐ | ☐ _____ Ovarian Cancer | ☐ | ☐ _____ Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Genital & Urinary Systems**

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Kidney Stones | ☐ | ☐ _____ | Erectile Dysfunction or Sexual Dysfunction |
| ☐ | ☐ _____ | Gout | | | |
| ☐ | ☐ _____ | Interstitial Cystitis | ☐ | ☐ _____ | Frequent Yeast Infections |
| ☐ | ☐ _____ | Frequent urinary tract infections | ☐ | ☐ _____ | Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Musculoskeletal/Pain**

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Osteoarthritis | ☐ | ☐ _____ | Sore muscles or joints, undiagnosed |
| ☐ | ☐ _____ | Fibromyalgia | | | |
| ☐ | ☐ _____ | Chronic Pain | ☐ | ☐ _____ | Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Immune/Inflammatory**

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Chronic Fatigue Syndrome | ☐ | ☐ _____ | Psoriasis |
| ☐ | ☐ _____ | Rheumatoid Arthritis | ☐ | ☐ _____ | Mixed Connective Tissue Disease (MCTD) |
| ☐ | ☐ _____ | Lupus SLE | | | |
| ☐ | ☐ _____ | Raynaud's | | | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Poor immune function (frequent infections) | ☐ | ☐ _____ | Hepatitis |
| ☐ | ☐ _____ | Food allergies | ☐ | ☐ _____ | Lyme (and co-infections) |
| ☐ | ☐ _____ | Environmental allergies | ☐ | ☐ _____ | Chronic Infections (Epstein-Barr, Cytomegalovirus, Herpes, etc.) |
| ☐ | ☐ _____ | Multiple chemical sensitivities | | | |
| ☐ | ☐ _____ | Latex allergy | ☐ | ☐ _____ | Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Respiratory Conditions**

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Asthma | ☐ | ☐ _____ | Sleep Apnea |
| ☐ | ☐ _____ | Chronic Sinusitis | ☐ | ☐ _____ | Frequent or recurrent Colds/Flus |
| ☐ | ☐ _____ | Bronchitis | | | |
| ☐ | ☐ _____ | Emphysema | ☐ | ☐ _____ | Other |
| ☐ | ☐ _____ | Pneumonia | | | |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Skin Conditions**

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Eczema | ☐ | ☐ _____ | Acne |
| ☐ | ☐ _____ | Psoriasis | ☐ | ☐ _____ | Skin Cancer (Melanoma) |
| ☐ | ☐ _____ | Dermatitis | ☐ | ☐ _____ | Skin Cancer (Squamous, Basal) |
| ☐ | ☐ _____ | Hives | | | |
| ☐ | ☐ _____ | Rash, undiagnosed | ☐ | ☐ _____ | Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Neurologic/Mood**

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Depression | ☐ | ☐ _____ | Memory problems |
| ☐ | ☐ _____ | Anxiety | ☐ | ☐ _____ | Parkinson's Disease |
| ☐ | ☐ _____ | Bipolar Disorder | ☐ | ☐ _____ | Multiple Sclerosis |
| ☐ | ☐ _____ | Schizophrenia | ☐ | ☐ _____ | ALS |
| ☐ | ☐ _____ | Headaches | ☐ | ☐ _____ | Seizures |
| ☐ | ☐ _____ | Migraines | ☐ | ☐ _____ | Alzheimer's |
| ☐ | ☐ _____ | ADD/ADHD | ☐ | ☐ _____ | Concussion/Traumatic |
| ☐ | ☐ _____ | Autism | | | Brain Injury |
| ☐ | ☐ _____ | Mild Cognitive Impairment | ☐ | ☐ _____ | Other |

Please briefly describe your symptoms, chosen treatment(s) and dates:

**Miscellaneous**

| past | now date | | past | now date | |
|---|---|---|---|---|---|
| ☐ | ☐ _____ | Anemia | ☐ | ☐ _____ | Whooping Cough |
| ☐ | ☐ _____ | Chicken Pox | ☐ | ☐ _____ | Tuberculosis |
| ☐ | ☐ _____ | German Measles | ☐ | ☐ _____ | Known genetic variants |
| ☐ | ☐ _____ | Measles | | | (SNPs, polymorphisms, etc) |
| ☐ | ☐ _____ | Mononucleosis | ☐ | ☐ _____ | Other |
| ☐ | ☐ _____ | Mumps | | | |

Please briefly describe your symptoms, chosen treatment(s) and dates:

34. Please check frequency of the following:

| | | | |
|---|---|---|---|
| Short term memory impairment | ☐ yes | ☐ no | ☐ sometimes |
| Shortened focus of attention and ability to concentrate | ☐ yes | ☐ no | ☐ sometimes |
| Coordination and balance problems | ☐ yes | ☐ no | ☐ sometimes |
| Problems with lack of inhibition | ☐ yes | ☐ no | ☐ sometimes |
| Poor organization abilities | ☐ yes | ☐ no | ☐ sometimes |
| Problems with time management (late or forget appts) | ☐ yes | ☐ no | ☐ sometimes |
| Mood instability | ☐ yes | ☐ no | ☐ sometimes |
| Difficulty understanding speech and word finding | ☐ yes | ☐ no | ☐ sometimes |
| Brain fog, brain fatigue | ☐ yes | ☐ no | ☐ sometimes |
| Lower effectiveness at work, home or school | ☐ yes | ☐ no | ☐ sometimes |
| Judgment problems like leaving the stove on, etc | ☐ yes | ☐ no | ☐ sometimes |

**HEALTH HAZARDS**

35. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

36. Do odors affect you?

37. Are you or have you been exposed to second-hand smoke?

38. Are you currently or have you been exposed to mold? (If so, what is/was the source of the exposure and for how long have you been/were you exposed to mold, if known?)

**ORAL HEALTH HISTORY**

39. How long since you last visited the dentist? What was the reason for that visit?

40. In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

41. What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

42. Do you have any mercury amalgams? (If no, were they removed? If so, how?)

43. Have you had any root canals? (If yes, how many and when?)

44. Do you have any concerns about your oral or dental health? (gums bleed after flossing, receding gums)

45. Is there anything else about your current oral or dental health or health history that you'd like us to know?

**LIFESTYLE HISTORY**

46. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

47. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

48. How do you handle stress?

**SLEEP HISTORY**

49. Are you satisfied with your sleep?

50. Do you stay awake all day without dozing?

51. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

52. Do you fall asleep in less than 30 minutes?

53. Do you sleep between 6 and 8 hours per night?

**FOR WOMEN ONLY**

54. How old were you when you first got your period?

55. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

56. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

57. Have you experienced any yeast infections or urinary tract infections? Are they regular?

58. Have you/do you still take birth control pills: If so, please list length of time and type.

59. Have you had any problems with conception or pregnancy?

60. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

**SEXUAL HISTORY**

61. Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

62. In the past year, have your sexual partners been men, women, or both? And how many partners have you had in the past year?

**MENTAL HEALTH STATUS**

63. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

64. On a scale of 1–10, one being the worst and 10 being the best, describe your usual level of energy.

65. At what point in your life did you feel best? Why?

**OTHER**

66. What role do you play in your wellness plan?

67. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

68. Who in you family or on your health care team will be most supportive of you making dietary change?

69. Please describe any other information you think would be useful in helping to address your health concern(s):

70. What are your health goals and aspirations?

71. Though it may seem odd, please consider why you might want to achieve that for yourself: