

CLIENT INTAKE FORM

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

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 _____

Partner's gender at birth _____

Partner's chosen gender _____

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?

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
- alcohol
- fast food
- gluten (wheat, rye, barley)
- dairy (milk, cheese, yogurt)
- coffee

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
- 20
- 30
- 40
- 50
- 60
- 70
- 80
- 90
- 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 and 3) If 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	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gut infections
<input type="checkbox"/>	<input type="checkbox"/>	_____	Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dysbiosis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcertative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Leaky gut
<input type="checkbox"/>	<input type="checkbox"/>	_____	Gastritis or Peptic Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Food allergies, intolerances or reactions
<input type="checkbox"/>	<input type="checkbox"/>	_____	GERD (reflux or heartburn)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	_____	Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Known absorption or assimilation issues
<input type="checkbox"/>	<input type="checkbox"/>	_____	SIBO	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other

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

Cardiovascular

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypertension (high blood pressure)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	_____	Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other
<input type="checkbox"/>	<input type="checkbox"/>	_____	Arrhythmia (irregular heartbeat)				

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

Hormones/Metabolic

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Polycystic Ovarian Syndrome (PCOS)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	_____	Metabolic Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	Weight gain
<input type="checkbox"/>	<input type="checkbox"/>	_____	Insulin Resistance or Pre-Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Weight loss
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypothyroidism (low thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent weight fluctuations
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hyperthyroidism (overactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hashimoto's (autoimmune hypothyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Menopause difficulties
<input type="checkbox"/>	<input type="checkbox"/>	_____	Grave's Disease (autoimmune hyperthyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hair loss
				<input type="checkbox"/>	<input type="checkbox"/>	_____	Other

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

Cancer

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prostate Cancer
<input type="checkbox"/>	<input type="checkbox"/>	_____	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Melanoma)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Squamous, Basal)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other

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

Genital & Urinary Systems

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	Interstitial Cystitis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent urinary tract infections

_____ Erectile Dysfunction or Sexual Dysfunction

_____ Frequent Yeast Infections
 _____ Other

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

Musculoskeletal/Pain

PAST NOW DATE
 _____ Osteoarthritis
 _____ Fibromyalgia
 _____ Chronic Pain

PAST NOW DATE
 _____ Sore muscles or joints, undiagnosed
 _____ Other

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

Immune/Inflammatory

PAST NOW DATE
 _____ Chronic Fatigue Syndrome
 _____ Rheumatoid Arthritis
 _____ Lupus SLE
 _____ Raynaud's
 _____ Psoriasis
 _____ Mixed Connetive Tissue Disease (MCTD)
 _____ Poor immune function (frequent infections)
 _____ Food allergies

PAST NOW DATE
 _____ Environmental allergies
 _____ Multiple chemical sensitivities
 _____ Latex allergy
 _____ Hepatitis
 _____ Lyme (and co-infections)
 _____ Chronic Infections (Epstein-Barr, Cytomegalovirus, Herpes, etc.)
 _____ Other

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

Respiratory Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	_____	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent or recurrent Colds/Flus
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other
<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema				
<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia				

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

Skin Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Acne
<input type="checkbox"/>	<input type="checkbox"/>	_____	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Melanoma)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Squamous, Basal)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other
<input type="checkbox"/>	<input type="checkbox"/>	_____	Rash, undiagnosed				

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

Neurologic/Mood

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mild Cognitive Impairment
<input type="checkbox"/>	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Memory problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	_____	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALS
<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	_____	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alzheimer's
<input type="checkbox"/>	<input type="checkbox"/>	_____	Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Concussion/Traumatic Brain Injury

_____ Other

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

Miscellaneous

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	_____	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Whooping Cough
<input type="checkbox"/>	<input type="checkbox"/>	_____	German Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	Known genetic variants (SNPs, polymorphisms, etc)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other

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

34. Please check frequency of the following:

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