Client Intake Form

**Please answer each question to the best of your ability. Your answers provide me with the information I need to better assess and provide treatment for you. If you have any questions about anything on this form, please ask. Thank you for your time and I look forward to working with you!**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_ Zipcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Sex: M (X) F Status: Single Married

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List all Medical or Alternative Practitioners whose care you are under:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For what reason have you seen these practitioners (illness, medical condition, accident, physical, therapy, etc.)

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Please list all current symptoms from most severe to least severe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all current treatment approaches for these symptoms (e.g. Gluten free diet)

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**Family History**

Please check all that apply.

* Allergies (including food allergies)
* Cancer
* Heart Disease
* Lyme
* Celiac Disease
* Eating Disorders
* Depression/Anxiety
* Anemia
* Fibromyalgia/Chronic Fatigue
* Hashimoto’s/Hypothyroidism
* Migraines
* Obesity
* Diabetes
* Autoimmune Conditions… if yes, which conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Dementia/Alzheimer’s
* Liver Disease
* Multiple Sclerosis
* Stomach issues
* Other Mental Illness
* Hypoglycemia

Any other conditions not listed above, please list here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History**

Please list all the people you live with, their age and their relationship to you.

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Have you or your family experienced any major life events/changes in the past year?

If yes, please elaborate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have your symptoms impacted your life in a detrimental way? If yes, please explain how.

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Do you feel that the people close to you are supportive?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any family members or friends that can potentially hinder healing?

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On a scale from 1 to 10 with 1 being the worst and ten being the best, how would you rate your overall life satisfaction right now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If it is not 10, please explain here. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical History**

Please indicate which of the following pertain to you and when it occurred.

*Condition/Operation: When?*

* Anemia
* Arthritis
* Asthma
* Bronchitis
* Cancer
* Candida
* Chronic Fatigue
* Chron’s Disease/ Ulcerative Colitis
* Celiac Disease
* Diabetes
* Emphysema
* Epilepsy/Seizures
* Epstein Barr (Mono)
* Gallstones
* Gout
* Heart Attack
* Heart Disease
* Heart Failure
* Hepatitis
* Herpes
* High Cholesterol/Triglycerides
* Hypertension
* High Blood Sugar
* HIV
* Hypoglycemia
* Irritable Bowel
* Kidney Stones
* Lyme Disease
* Pneumonia
* Rheumatic Fever
* Sinusitis….sinus infection
* Sleep Apnea
* Trouble Sleeping X
* Thyroid Disease
* Back injury
* Broken Bones
* Head Injury
* Appendectomy
* Dental Surgery
* Gall Bladder
* Hernia
* Hysterectomy
* Tonsillectomy

Please list any conditions not included on this sheet:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any operations not included on this sheet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you take antibiotics as a child? Y N

Did you take antibiotics as a teen? Y N

Did you take antibiotics as an adult? Y N

Please list any medications you are currently taking (prescription & over-the-counter).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Date Started** | **Dosage** | **How often?** | **Consistently?** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |

Please list any medications not listed above here. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any vitamins or supplements that you are currently taking below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Vitamin/Mineral/Herbal**  **Supplement** | **Date Started** | **Dosage** | **How Often?** | **Consistently?** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |

**Dietary History**

Please describe a typical day of eating below:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Dessert:

How many glasses of water do you drink a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume organic fruits and vegetables? Y N

Are you on any special diet? If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How often do you eat candy a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many sodas (diet or regular) do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many cups of coffee do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have symptoms after eating any specific foods or supplements (sneezing, itching, bloating, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any delayed symptoms after eating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any foods that you crave and tend to eat large quantities of? If yes, please list them below.

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Do you have any food aversions? If yes, please list them below.

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Who prepares the meals in your house? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply to your eating habits.

|  |  |
| --- | --- |
| * I eat out at restaurants \_\_\_\_\_\_\_times per week. | * I binge eat \_\_\_\_\_\_\_\_ times a week, and \_\_\_\_\_\_ times a month. |
| * Emotional Eating | * No time to eat regularly. |
| * Don’t know what to eat | * I love food and it loves me. |
| * Chocolate is my weakness | * Don't know how to exercise |
| * Hate to exercise | * I don't have the money to eat healthy. |
| * Meal Planning | * Picky Eater |
| * Self-Esteem | * Negative Self Talk |
| * Family Influences and Peers | * Home is my downfall |
| * Work is my downfall | * Medical Reasons |
| * Parties and Social Events… | * Motivation |
| * Lack of Focus | * Cravings |
| * Hunger | * Tradition and genetics are my challenge |
| * Habits or Patterns | * Unconscious Eating |
| * Comfort Foods | * Too Tired |
| * Snacking, Grazing, and Nibbling | * Too busy |
|  |  |

**Drugs and Alcohol**

Have you ever consumed alcohol? Y N

Do you currently drink alcohol? Y N

If yes, how many drinks do you have a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used drugs? Y N

Do you smoke or chew tobacco? Y N

If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to second hand smoke regularly? Y N

**Toxin Exposure**

Do you have mercury amalgam dental fillings? Y N

Have you ever lived in a dwelling with mold? Y N

Do you work in a job that exposes you to hazardous chemicals? Y N

**Physical Activity**

What do you like to do for fun? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you exercise regularly? Y N

If yes, how many times a week do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long are your exercise sessions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do for exercise (e.g. running, tennis, yoga, etc.)?

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How do you feel after exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any barriers or issues with exercise? Y N

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your occupation involve any sort of movement or physical activity? Y N

**Symptom Checklist**

Please check all the symptoms that have occurred in the last 6 months or are currently ongoing.

General:

* Cold hands and feet
* Cold intolerance
* Daytime sleepiness
* Difficulty falling asleep
* Early waking
* Fatigue
* Fever
* Flushing
* Heat intolerance
* Night waking
* Nightmares
* Numb fingers and toes
* No dream recall
* Sensitive to minor changes in weather
* Tired, sluggish
* Unintentional weight loss

Head, Eyes, Nose & Ears:

* Burning of eyes
* Conjunctivitis
* Discharge from eyes
* Distorted sense of smell
* Distorted taste
* Ear fullness
* Ear noises
* Ear pain
* Ear ringing/buzzing
* Eye crusting
* Eye pain
* Headache
* Hearing loss
* Hearing problems
* Lid margin redness
* Migraine
* Nasal congestion or discharge
* Sensitivity to loud noises
* Vision problems

Musculoskeletal:

* Abdominal cramps, aches
* Back muscle spasm
* Calf cramps
* Chest tightness
* Foot cramps
* Joint deformity
* Joint pain
* Joint redness
* Joint stiffness
* Muscle pain
* Muscle spasms
* Muscle stiffness
* Muscle twitches
* Muscle weakness
* Tendonitis
* Tension headaches
* TMJ problems

Mood/Nerves:

* Agoraphobia
* Anxiety
* Auditory hallucinations
* Black-out
* Depression
* Difficulty concentrating
* Difficulty with balance
* Difficulty with thinking
* Difficulty with judgment
* Difficulty with speech
* Difficulty with memory
* Dizziness
* Fainting
* Fearfulness
* Irritability
* Light-headedness
* Mood swings
* Numbness
* Panic Attacks
* Paranoia
* Restless, agitated, angry
* Suicidal thoughts
* Tingling
* Tremor/Trembling
* Visual Hallucinations

Eating:

* Bing eating
* Bulimia
* Can’t gain weight
* Can’t lose weight
* Carbohydrate craving
* Carbohydrate intolerance
* Feeling hungry an hour or two after eating
* Poor appetite
* Sense of fullness during and after meals
* Salt craving

Digestion:

* Bad teeth
* Bleeding gums
* Bloating
* Blood in stools
* Burping
* Canker sores
* Cold sores
* Constipation
* Cracking at corner of lips
* Dentures w/poor chewing
* Diarrhea
* Difficulty swallowing
* Dry mouth
* Farting
* Bowl pain
* Fissures
* Reflux
* Heartburn
* Hemorrhoids
* Indigestion
* Intolerance to Lactose
* Intolerance to Gluten
* Intolerance to Corn
* Intolerance to Eggs
* Intolerance to Fatty foods
* Intolerance to Yeast
* Liver disease/jaundice
* Lower abdominal pain
* Mucus in stools
* Nausea
* Periodontal disease
* Sore tongue
* Sores in mouth
* Strong stool odor
* Undigested food in stools
* Upper abdominal pain
* Vomiting

General Skin Problems:

* Acne on back
* Acne on chest
* Acne on face
* Acne on shoulders
* Athlete’s foot
* Blotchy skin
* Bruising easily
* Bumps on back of upper arms
* Cellulite
* Dark circles under eyes
* Easy bruising
* Scalp
* Eczema
* Herpes- genital
* Hives
* Loss of hair
* Oily skin
* Pale skin
* Psoriasis
* Puffy hands, face and feet
* Rash
* Red face
* Sensitive to bites
* Shingles
* Skin Cancer
* Strong body odor
* Swollen eyelids

Lymph Nodes:

* Enlarged/neck
* Tender/neck
* Other enlarged/tender lymph nodes

Nails:

* Bitten
* Brittle
* Curve up
* Discolorations
* Frayed
* Fungus
* Pitting
* Soft
* White spots/lines

Respiratory:

* Bad breath
* Bad odor in nose
* Chest pain
* Cough
* Difficulty breathing
* Hoarseness
* Nasal Stuffiness
* Nose bleeds
* Post nasal drip
* Sinus fullness
* Sinus infection
* Snoring
* Sore throat
* Wheezing

Cardiovascular:

* Angina/chest pain
* Breathlessness
* Heart attack
* Heart burn
* Heart murmur
* High blood pressure
* Irregular pulse
* Phlebitis
* Pounding heart
* Swollen ankles/feet
* Varicose veins
* Slow heart beat

Urinary:

* Bed wetting
* Dark urine
* Hesitancy
* Increased frequency
* Infection
* Kidney disease
* Kidney stone
* Leaking/incontinency
* Pain/burning
* Prostate enlargement
* Prostate infection
* Urgency

Male Reproductive:

* Discharge from penis
* Ejaculation problem
* Genital pain
* Impotence
* Infection
* Lumps in testicles
* Poor libido

Female Reproductive:

* Breast cysts
* Breast lumps
* Breast tenderness
* Ovarian cyst
* Poor libido
* Endometriosis
* Fibroids
* Infertility
* Vaginal discharge
* Vaginal odor
* Vaginal itch
* Vaginal pain
* Heavy menstrual periods
* Irregular periods
* No periods
* Heavy menstrual cramps
* Spotting between periods

For Women Only:

Have you ever been pregnant? Y N

Number of miscarriages \_\_\_\_\_\_\_\_ Number of abortions \_\_\_\_\_\_\_ Number of preemies \_\_\_\_\_\_\_ Number of term births \_\_\_\_\_\_

Did you develop toxemia? Y N

Any other issues with pregnancy? Y N

If yes, please explain.

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Date of first period \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Pap \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Normal or Abnormal Pap? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking birth control pills? Y N

Are you currently sexually active? Y N

Are you in menopause? Y N

Do you take hormone replacement? Y N

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to accomplish with your treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_