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a natural approach to health

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New Client Intake Form

Personal Information

Name_____Age___Date of Birth__/__/____Sex: F M

Address_____City_____State_____Zip_____

Phone: _____Alternate_____

Email_____

Would you like to receive my e-newsletter: Yes No

Occupation_____Employer_____

Emergency Contact_____Relationship_____Phone_____

How did you hear about me_____

Primary health concerns in order of importance:

1._____

2._____

3._____

4._____

Your health goals (i.e desired outcome of us working together) in order of importance:

1._____

2._____

3._____

4._____

Medical History

When did you last receive healthcare?_____

What was the reason_____

Preventative screenings. When was your last:

Blood Work_____

Eye exam_____

Dental exam_____

Colonoscopy_____ Was it normal: Y N

DEXA scan_____ Was it normal: Y N

Pap exam (women only)_____Was it normal: Y N

Mammogram exam (women only)_____Was it normal: Y N

Prostate exam (men only)_____Was it normal: Y N

Allergies:

To Medications_____

To Foods_____

Environmental_____

Past surgeries and/or hospitalizations:

1._____Date_____
2._____Date_____
3._____Date_____
4._____Date_____

Medications you are taking with dosage:

1._____
2._____
3._____
4._____
5._____

Supplements you are taking with brand and dosage:

1._____
2._____
3._____
4._____
5._____

Social History

How much water do you drink per day in ounces_____

Coffee in cups per day_____Soda in ounces_____

Use of the following: write **C** for current use and **P** for past use

Alcohol_____Drinks per week_____

Recreational drugs_____Frequency_____

Tobacco products_____Frequency_____

Sleep: Circle all that apply:

No problems with sleep Wakes refreshed

Difficulty falling asleep Difficulty staying asleep

Waking un-refreshed Hours per night_____

Rate your energy: please circle

lowest 0 1 2 3 4 5 6 7 8 9 10 highest

Is your energy where you want it to be? Y N

Bowel movements: Number per day_____Circle all that apply:

Undigested food Mucous Blood Painful Urgent

Exercise frequency per week_____Type_____

Family History

Please indicate any known health condition and age at death and reason for death if applicable for the following relatives:

Mother_____

Maternal grandmother_____

Maternal grandfather_____

Father_____

Paternal grandmother_____

Paternal grandfather_____

Siblings_____

Review of Systems

Next to the following symptoms circle **C** for currently experiencing, **P** for past or leave it blank if it has never affected you:

Headaches: C P
Dizziness: C P
Frequent ear infections: C P
Recurrent sinus infections: C P
Recurrent UTIs: C P
Asthma: C P
Heart disease: C P
High blood pressure: C P
High Cholesterol: C P
Anemia: C P
Hypothyroid: C P
Hyperthyroid: C P

Autoimmune disease: C P
Diabetes: C P
Cancer: C P
IBS or IBD: C P
Constipation: C P
Diarrhea: C P
Heartburn: C P
Anxiety: C P
Depression: C P
Eating disorder: C P
Other_____
Other_____

Any thing else you'd like to tell me about you or your health?

_____

_____

_____