Client In-Take Form

Name:_____ **DOB:**_____

Please take a few minutes, before your appointment, to complete these questions. My approach to healing/wellness is to start at your present situation in life and move forward, together, to incorporate mindful and functional lifestyle changes to improve overall health and happiness. Please be honest in your responses, as your answers will guide the formation of our plan for improving your health and wellness moving forward. Thank you for sharing your journey with me and I hope we both learn from our time together!

Client Information

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: (home):_____ (work):_____ (cell):_____

Email:_____

Referred by:_____

Emergency contact information:

Name:_____

Relationship:_____ Phone:_____

Statistics

Birthdate:_____ Age:_____

Gender:_____

Height:_____ ft _____ in Current Weight:_____ Ideal Weight:_____

Weight six months ago:_____ Weight one year ago:_____

Birth weight:_____ Place of birth:_____

Family/Living Situation:_____

Children:_____

Pets:_____

Relationship Status:_____

Occupation:_____

Exercise and Recreation:_____

_____

Name:_____ **DOB:**_____

Current Concerns and Goals

What are your main health concerns (please be detailed, including severity and duration of symptoms):_____

_____

_____

What treatments have you tried for your health concerns in the past (if any)?_____

_____

_____

What was your experience with the treatments you previously tried?_____

_____

_____

What are your goals for this appointment?_____

_____

_____

_____

Please list other health professionals you are currently seeing? Include name, specialty and contact information:_____

_____

_____

History

Birth and early history if known (please circle one):

Method of Delivery:	Vaginal	C-Section
Mode of Feeding:	Breast-fed	Formula-fed

If breast-fed, how long?_____ Other info:_____

Have you ever traveled outside the US? If so, when and where?_____

_____

_____

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

_____

Name:_____ **DOB:**_____

Have you experienced any major losses in life? If so, please comment:_____

_____

_____

How much time have you taken off from work or school in the past year due to illness (please circle one)?

0-2 days 3-14 days 15 or more days

Please list all surgical procedures, including dates and a brief description:_____

_____

_____

Please list all medications you are currently taking (include all prescription, over-the-counter, vitamins, and supplements **with dosage**):_____

_____

_____

Please tell me about your history of taking antibiotics:_____

_____

Family and Friends

Family member	Current Age	Current or past mental health or medical issues, allergies, sensitivities, and/or intolerances	Please describe your current level of connectedness to this family member
Father			
Mother			
Paternal grandfather			
Paternal grandmother			
Maternal grandfather			
Maternal grandmother			
Sibling			
Sibling			
Children			
Children			

Please describe your current support system including family, friends, neighbors, co-workers, etc:_____

_____

Name:_____ **DOB:**_____

Nutritional Status

Do you consider yourself a (please circle one if applicable:

Meat Eater Vegetarian Vegan

What foods did you eat often as a child:_____

_____

_____

Please describe your current diet:

Breakfast:_____

Lunch: _____

Dinner:_____

Snacks:_____

Liquids:_____

Please list your 3 favorite meals to cook at home:

1) _____

2) _____

3) _____

Please list your 3 favorite meals to order when dining out:

1) _____

2) _____

3) _____

What oils do you cook with at home?_____

Are there foods you dislike? If so, please list and estimate last date tried:_____

_____

Are there foods you avoid because of how they make you feel? If so, please name food and describe symptoms experienced:_____

_____

Have you ever been diagnosed with a food allergy, sensitivity, and/or intolerance? If so, please comment on details:_____

_____

Name:_____ **DOB:**_____

Do you have any other symptoms associated with eating? These can include gas, bloating, sneezing, hives, sinus congestion and others:_____

_____

_____

Do you have any symptoms consistent with delayed food sensitivity reactions? These can include fatigue, brain fog, muscle or joint aches, sinus issues, and many more:_____

_____

_____

Do you experience food cravings? If so, what and when, if applicable:_____

_____

Which of these foods do you consume regularly (please circle one)

Soda	Refined sugar	Coffee
Diet Soda	Milk, cheese or yogurt	Alcohol
Fast Food	Gluten (wheat, rye, or barley)	

Are you currently on a special diet (please circle if on currently and square if on in past)?

Lacto-ovo	Vegan	Refined sugar-free
Diabetic	Vegetarian	Gluten-free
Dairy-free	Blood Type	Other:_____
Paleo	Raw	_____

Please estimate the percentage of meals you believe are cooked at home (please circle)?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Where do you obtain the remainder of your meals?_____

_____

How much water do you drink daily?_____

Is there anything else you want me to know regarding your diet, history, or relationship to food?_____

_____

_____

_____

_____

Name:_____ **DOB:**_____

Digestive Status

Bowel Movement Frequency (please circle one):

More than 3x daily 1-3x daily Not every day

If more than 3x daily, how often?_____ If not every day, how often?_____

Bowel Movement Consistency (please circle one):

Soft and well formed	Thin, long or narrow	Loose
Sometimes floats	Small and hard	Diarrhea
Hard or painful to pass	Alternating between hard and loose	

Bowel Movement Color (please circle one):

Medium brown	Blood visible (bright red)	Chalky color
Very dark or black	Variable	Greasy, shiny
Greenish	Yellow or light brown	Mucus

Do you experience intestinal gas? Please describe how often, odor, and associated pain or discomfort:_____

_____

Do you experience heartburn? Please describe how often, food responsible if known, associated pain or discomfort, and usual treatment:_____

_____

Medical History

Please circle any condition that you have experienced in your past. Describe symptoms, treatments, and dates experienced.

Heart Disease	Hepatitis	Diabetes
High Blood Pressure	Venereal disease	Asthma
High Cholesterol	Thyroid disease	Anemia
Chronic yeast infections	Depression	Allergies

Cancer (please include type, stage and date of diagnosis and/or remission):_____

_____

_____

What is your ancestry?_____ Blood type:_____

Name:_____ **DOB:**_____

Environmental Exposures

Have you ever been exposed to any chemicals or toxic metals including lead, mercury, arsenic, aluminum, etc?_____

_____

What cleaning products do you use in your home?_____

_____

Do odors affect you? If so, which ones and what are your symptoms?_____

_____

Have you been exposed to second-hand smoke? If yes, please comment:_____

_____

Do you have mercury amalgam fillings?_____

What self-care products do you use (deodorant, lotion, shampoo & conditioner, make-up, etc)?_____

_____

Lifestyle History

Have you had times of struggle with binge eating or dieting in the past? Do you still? Please list all diets you have been on for longer than 3 months:_____

_____

Have you used or abused alcohol, drugs, medications, tobacco, or caffeine? Do you still? Please include frequency of use:_____

_____

How would you rate your stress level (1 is low and 10 is high)?_____

How do you deal with stress?_____

_____

Describe your average night's sleep:_____

_____

How would you rate your energy level (1 is low and 10 is high)?_____

_____

How much time do you spend on the computer/phone/tablet each day?_____

_____

Name:_____ **DOB:**_____

What are your current exercise habits?_____

_____

How much do you spend weekly on groceries?_____ Do you buy organic? Y N

Where do you normally shop?_____

Appointment Information

What are the preferred days and times for your future appointments?_____

_____

_____

Responsible Party

Printed name of person responsible for payment of this appointment:

_____

Signature:_____ Date:_____

My Promise to You

During our work together, I promise to meet you at your current place in life and work on achievable strategies to improve and/or optimize your health. I promise to be a good listener, I promise to be open to your way of doing things, and I promise to gently hold you accountable to yourself. Thank you for sharing your time and your journey with me!

Your Promise to You

Our work is built on the foundation of my solid belief that you are an amazing, unique individual who deserves love, care, and support, especially from yourself. In order for our time to be successful, you must whole-heartedly believe this too. Together, we will harness the healing power of nature with your body's intrinsic ability to heal to achieve your goals.

Your signature:_____ Date:_____

My signature:_____ Date:_____

THANK YOU! **With love, Amy**

Name:_____ **DOB:**_____