# CLIENT INTAKE FORM

| | | | | | |
|---|---|---|---|---|---|
| Today's Date: | | Date of Birth: | | Date Pictures Were Taken: | |
| Name: | | | Email: | | |
| Street Address: | | | | City/Province: | |
| State: | | Zip/Postal Code: | | Country: | |
| Cell: | | Home: | | Work: | |
| Occupation: | | | Work Hours Per Week: | | |
| Emergency Contact: | | Phone: | | Relation | |
| Family Physician/Address/Phone: | | | | | |
| Relationship Status: | | Blood Type? | | https://www.4yourtype.com/original-home-blood-typing-kit/ | |
| Children: | | If so, their ages: | | If pregnant, what trimester? | |
| Pets: | ☐ Yes | ☐ No | How many? | Type(s): | |
| Height: | | Weight: | | Weight One Year Ago: | |
| Reason for today's visit: | | | Expected Outcome: | | |
| Circle healthcare practitioners you are currently receiving treatment: | | Acupuncture | Chiropractic | NAET | |
| Naturopathic | Osteopathy | Physiotherapy | Reflexology | | |
| If currently under physician's care, what is the medical problem(s)? | | | | | |
| Birth Diagnosis? | | Other Diagnosis? | | | |

**MAIN COMPLAINTS: List your present health problems:**

| | | | | | |
|---|---|---|---|---|---|
| 1. | | 2. | | 3. | |
| 4. | | 5. | | 6. | |
| 7. | | 8. | | 9. | |

| | |
|---|---|
| At what point in your life did you feel your best? | Current health state? |
| What are your health goals? | |

| | | | |
|---|---|---|---|
| 1. | | 2. | |
| 3. | | 4. | |
| 5. | | 6. | |
| 7. | | 8. | |

**HEALTH HISTORY: List any surgeries, major illnesses, seizures, or accidents with approximate dates:**

| Surgeries/Illness/Accidents | Date/Duration | Outcome | Recovered? | Therapy? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**List any family history of serious illnesses: Check off all that apply.**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Cancer | Type | | Relation | |
| ☐ | Diabetes | Type | | Relation | |
| ☐ | Heart Disease | Type | | Relation | |
| ☐ | Mood Disorders, including Depression & Anxiety | Type | | Relation | |
| ☐ | Alzheimer's Dementia | Stage | | Relation | |

Please circle all that apply, where applicable; and fill in your answers in the blank spaces provided. Follow key below.

0=None | 1=Yes; mild symptom, rarely occurs | 2=Moderate symptom; occurs weekly | 3=Severe symptom; occurs daily

## MTHFR

☐ MTHFR: A1298C Positive ☐ MTHFR: C677T Positive

☐ Autism ☐ ADHD ☐ ADD ☐ MS

☐ H-Pylori (B12 not processed)

Basal Temp

Saliva pH _____ Urine pH

TSH (thyroid stimulating hormone) Level

Vitamin A Level

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Acute leukemia |
| 0 | 1 | 2 | 3 | Allergies (Histamine Errors) |
| 0 | 1 | 2 | 3 | Anxiety |
| 0 | 1 | 2 | 3 | Bipolar disorder |
| 0 | 1 | 2 | 3 | Cardiovascular and Thromboembolic diseases (specifically blood clots, stroke, embolism, and heart attacks) |
| 0 | 1 | 2 | 3 | Chronic pain and fatigue |
| 0 | 1 | 2 | 3 | Colon cancer |
| 0 | 1 | 2 | 3 | Depression |
| 0 | 1 | 2 | 3 | Hashimoto's (Thyroid issues) |
| 0 | 1 | 2 | 3 | High Cholesterol (Fatty Liver) |
| 0 | 1 | 2 | 3 | Leaky Gut Syndrome |
| 0 | 1 | 2 | 3 | Migraines |
| 0 | 1 | 2 | 3 | Nerve pain |
| 0 | 1 | 2 | 3 | Pregnancies with neural tube defects, like spina bifida and anencephaly |
| 0 | 1 | 2 | 3 | Schizophrenia |
| 0 | 1 | 2 | 3 | Recurrent miscarriages in child-bearing age |
| 0 | 1 | 2 | 3 | Anything else not identified above, use "Supplemental Information" on **p10** to explain, then check corresponding number on left |

← Total

## MTHFR: ESTROGEN DOMINANCE

| | |
|---|---|
| ☐ Mood Swings | ☐ Irritability |
| ☐ Decreased Sex Drive | ☐ Worsening PMS Symptoms |
| ☐ Irregular Menstrual Periods | ☐ Heavy Periods |
| ☐ Bloating | ☐ Weight Gain |
| ☐ Anxiety | ☐ Hair Loss |
| ☐ Trouble Sleeping | ☐ Fatigue |
| ☐ Fertility Issues | ☐ Hot flashes & night sweats |
| ☐ Memory Problems & Mental Fog | |

## MTHFR: BRCA 1&2/CHEK 2

| | |
|---|---|
| ☐ Breast Cancer | ☐ Colorectal Cancer |
| ☐ Kidney Cancer | ☐ Ovarian Cancer |
| ☐ Prostate Cancer | ☐ Thyroid Cancer |
| ☐ Fibrous Breasts | |

## MTHFR: AQUAPORIN AQP

| | |
|---|---|
| Liver Health | ☐ Heavy Metal Toxicity (Arsenic)<br>☐ Cholesterol<br>☐ Glucogenesis (Insulin Resistance, Diabetes) |
| Calcification | ☐ Arthritis<br>☐ Cataract<br>☐ Bone Spurs |
| Peripheral Circulation and Brain Health | ☐ Dementia<br>☐ Alzheimer's<br>☐ Reynaud's |

## SMOKING/VAPING HISTORY

History of smoking or vaping? Currently? Past? How long? Please explain.

## CURRENT RX, SUPPLEMENTS, ETC.

| Name | Dosages per day unless indicated |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## STRESS

1. How would you define the biggest stress challenges you are currently facing?
2. What are the things or people in your life that are causing problems for you?
3. How do these problems affect you?
4. Are you taking prescribed medication for your stress?
5. How many hours do you sleep?
6. How often do you exercise? Type?

Please circle all that apply. Follow key below.

0=None | 1=Yes; mild symptom, rarely occurs | 2=Moderate symptom; occurs weekly | 3=Severe symptom; occurs daily

| WOMEN'S PROBLEMS | | | | | MEN'S PROBLEMS | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Painful menstrual cycle | 0 | 1 | 2 | 3 | Prostate problems |
| 0 | 1 | 2 | 3 | Mood swings around cycle | 0 | 1 | 2 | 3 | Decreased libido |
| 0 | 1 | 2 | 3 | Painful breasts at cycle | 0 | 1 | 2 | 3 | Urination difficult |
| 0 | 1 | 2 | 3 | Irregular cycles | 0 | 1 | 2 | 3 | Pain or burning with urination |
| 0 | 1 | 2 | 3 | Heavy menstrual flow | 0 | 1 | 2 | 3 | Fatigue |
| 0 | 1 | 2 | 3 | Acne at menstrual cycle | 0 | 1 | 2 | 3 | Pain on inside of legs/heels |
| 0 | 1 | 2 | 3 | Yeast infections | 0 | 1 | 2 | 3 | Feeling of incomplete bowel |
| 0 | 1 | 2 | 3 | Endometriosis | | | | | ← Total |
| 0 | 1 | 2 | 3 | Uterine fibroids | **STOMACH** | | | | |
| 0 | 1 | 2 | 3 | Fibrocystic breasts | 0 | 1 | 2 | 3 | Heartburn or Acid Reflux |
| 0 | 1 | 2 | 3 | Hot flashes | 0 | 1 | 2 | 3 | Burping or Gas after eating |
| 0 | 1 | 2 | 3 | Vaginal itchiness | 0 | 1 | 2 | 3 | Bloating after eating |
| 0 | 1 | 2 | 3 | Vaginal discharge | 0 | 1 | 2 | 3 | Bad Breath |
| 0 | 1 | 2 | 3 | Night sweats | 0 | 1 | 2 | 3 | Sweat has a strong odor |
| 0 | 1 | 2 | 3 | Menopausal symptoms | 0 | 1 | 2 | 3 | Feel better if I do not eat |
| | | | | ← Total | 0 | 1 | 2 | 3 | Sleepy after meals |
| **SMALL INTESTINE** | | | | | 0 | 1 | 2 | 3 | Burning pain in stomach |
| 0 | 1 | 2 | 3 | Food allergies | 0 | 1 | 2 | 3 | Fingernails chip/break/peel |
| 0 | 1 | 2 | 3 | Bloating after eating | 0 | 1 | 2 | 3 | Anemia Unresponsive to iron |
| 0 | 1 | 2 | 3 | Airborne allergies | 0 | 1 | 2 | 3 | Stomach pain or cramps |
| 0 | 1 | 2 | 3 | Wheat or gluten sensitivity | 0 | 1 | 2 | 3 | Diarrhea, chronic |
| 0 | 1 | 2 | 3 | Dairy sensitivity | 0 | 1 | 2 | 3 | Diarrhea after meals |
| 0 | 1 | 2 | 3 | Sinus congestion | 0 | 1 | 2 | 3 | Black or dark stool |
| 0 | 1 | 2 | 3 | Craves bread/pasta | 0 | 1 | 2 | 3 | Undigested food in stool |
| 0 | 1 | 2 | 3 | Pulse speeds after eating | | | | | ← Total |
| 0 | 1 | 2 | 3 | Nightmares | **LIVER** | | | | |
| 0 | 1 | 2 | 3 | Feel spacy or unreal | ☐ MTHFR Positive | | | | |
| 0 | 1 | 2 | 3 | Alternating diarrhea/constipations | 0 | 1 | 2 | 3 | Age or "Liver" spots |
| 0 | 1 | 2 | 3 | Hives | 0 | 1 | 2 | 3 | Easily intoxicated |
| | | | | ← Total | 0 | 1 | 2 | 3 | Gallbladder attacks or stones |
| **LARGE INTESTINE** | | | | | 0 | 1 | 2 | 3 | Greasy foods upset stomach |
| 0 | 1 | 2 | 3 | Skip days between bowels movements | 0 | 1 | 2 | 3 | Headache over eyes |
| 0 | 1 | 2 | 3 | Stools hard or difficult to pass | 0 | 1 | 2 | 3 | Hemorrhoids or varicose veins |
| 0 | 1 | 2 | 3 | Cramping on lower abdomen | 0 | 1 | 2 | 3 | Insomnia (Melatonin deficiency) |
| 0 | 1 | 2 | 3 | Mucus in stool | 0 | 1 | 2 | 3 | Nausea |
| 0 | 1 | 2 | 3 | IBS or colitis | 0 | 1 | 2 | 3 | Motion sickness |
| 0 | 1 | 2 | 3 | Yeast infections | 0 | 1 | 2 | 3 | Pain between shoulder blades |
| 0 | 1 | 2 | 3 | Nail fungus or athletes' foot | 0 | 1 | 2 | 3 | Pain under right rib cage |
| 0 | 1 | 2 | 3 | Dark circles under eyes | 0 | 1 | 2 | 3 | Sensitivity to perfumes/chemicals/etc. |
| 0 | 1 | 2 | 3 | History of parasites | 0 | 1 | 2 | 3 | Skin rashes/acne/eczema |
| | | | | ← Total | | | | | ← Total |

Revised: 04/2023

Please circle all that apply. Follow key below.

0=None | 1=Yes; mild symptom, rarely occurs | 2=Moderate symptom; occurs weekly | 3=Severe symptom; occurs daily

## MINERAL DEFICIENCIES

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Carpal Tunnel Syndrome |
| 0 | 1 | 2 | 3 | Osteoporosis or Osteopenia |
| 0 | 1 | 2 | 3 | Legs or foot cramps at rest |
| 0 | 1 | 2 | 3 | Pain or swelling in joints |
| 0 | 1 | 2 | 3 | Bursitis or tendonitis |
| 0 | 1 | 2 | 3 | Joints pop or crack |
| 0 | 1 | 2 | 3 | White spots on fingernails |
| 0 | 1 | 2 | 3 | Decreased taste or smell |
| | | | | ← Total |

## KIDNEY AND BLADDER

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Pain upon urination |
| 0 | 1 | 2 | 3 | Frequent bladder infections |
| 0 | 1 | 2 | 3 | Cloudy, bloody, or dark urine |
| 0 | 1 | 2 | 3 | Urine has strong odor |
| 0 | 1 | 2 | 3 | History of kidney stones |
| 0 | 1 | 2 | 3 | Dribbling urination |
| 0 | 1 | 2 | 3 | Pain in lower back |
| | | | | |
| | | | | ← Total |

## ADRENAL GLANDS

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Difficulty falling asleep |
| 0 | 1 | 2 | 3 | Slow starter in the morning |
| 0 | 1 | 2 | 3 | Become dizzy when standing suddenly |
| 0 | 1 | 2 | 3 | Difficulty holding chiropractic adjustments |
| 0 | 1 | 2 | 3 | Arthritis |
| 0 | 1 | 2 | 3 | Crave salty foods |
| 0 | 1 | 2 | 3 | Headache after exercise |
| 0 | 1 | 2 | 3 | Chronic low back pain |
| 0 | 1 | 2 | 3 | Clench or grind teeth |
| 0 | 1 | 2 | 3 | Perspire too easily |
| 0 | 1 | 2 | 3 | Hives |
| 0 | 1 | 2 | 3 | Brightness hurts eyes |
| 0 | 1 | 2 | 3 | Slow recovery from stress |
| | | | | ← Total |

## NOTES

## VITAMIN DEFICIENCIES

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Body jerks as falling asleep |
| 0 | 1 | 2 | 3 | Restless leg syndrome |
| 0 | 1 | 2 | 3 | Small bumps on back of arms |
| 0 | 1 | 2 | 3 | Heart races |
| 0 | 1 | 2 | 3 | Worrier/anxious |
| 0 | 1 | 2 | 3 | Nosebleeds |
| 0 | 1 | 2 | 3 | Bruise easily |
| 0 | 1 | 2 | 3 | Gums bleed easily |
| 0 | 1 | 2 | 3 | Depressed regularly |
| 0 | 1 | 2 | 3 | Numbness or tingling in body |
| 0 | 1 | 2 | 3 | Loss of muscle tone |
| 0 | 1 | 2 | 3 | Brightness hurts eyes (Vitamin A deficiency) |
| | | | | ← Total |

## IMMUNE SYSTEM

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Catch cold/flu easily |
| 0 | 1 | 2 | 3 | Runny or drippy nose |
| 0 | 1 | 2 | 3 | Swollen lymph nodes |
| 0 | 1 | 2 | 3 | Gets boils, cysts, sties |
| 0 | 1 | 2 | 3 | Poor wound healing |
| 0 | 1 | 2 | 3 | History of Epstein bar, mono, herpes, shingles, or chronic fatigue |
| | | | | ← Total |

## LYME DISEASE TRAITS

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Intense fatigue |
| 0 | 1 | 2 | 3 | Brain Fog |
| 0 | 1 | 2 | 3 | Memory loss-short/long term |
| 0 | 1 | 2 | 3 | Pain or swelling in joints |
| 0 | 1 | 2 | 3 | Stiff joints in morning |
| 0 | 1 | 2 | 3 | Muscle twitching |
| 0 | 1 | 2 | 3 | Unexplained fevers |
| 0 | 1 | 2 | 3 | Headaches/Migraines |
| 0 | 1 | 2 | 3 | Poor Concentration |
| 0 | 1 | 2 | 3 | Sore soles of feet in morning |
| | | | | ← Total |

## NOTES

Please circle all that apply. Follow key below.

0=None | 1=Yes; mild symptom, rarely occurs | 2=Moderate symptom; occurs weekly | 3=Severe symptom; occurs daily

## BLOOD SUGAR PROBLEMS

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Crave sweets |
| 0 | 1 | 2 | 3 | Awaken during night, hard to fall back asleep |
| 0 | 1 | 2 | 3 | Excessive appetite |
| 0 | 1 | 2 | 3 | Crave coffee or sugar in afternoon |
| 0 | 1 | 2 | 3 | Headache if meals are delayed |
| 0 | 1 | 2 | 3 | Get shaky or weak if hungry |
| 0 | 1 | 2 | 3 | Sleepy in afternoon |
| 0 | 1 | 2 | 3 | Fatigue relieved by eating |
| 0 | 1 | 2 | 3 | Afternoon headaches |
| 0 | 1 | 2 | 3 | Irritable before meal |
| | | | | ← Total |

## CARDIOVASCULAR SYSTEM

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Shortness of breath w/ moderate exertion |
| 0 | 1 | 2 | 3 | Opens windows in closed room |
| 0 | 1 | 2 | 3 | Sigh frequency |
| 0 | 1 | 2 | 3 | Bruise easily |
| 0 | 1 | 2 | 3 | Ankles swell at end of day |
| 0 | 1 | 2 | 3 | Muscle cramps during exercise |
| 0 | 1 | 2 | 3 | Hands and feet go to sleep |
| 0 | 1 | 2 | 3 | Dull pain in chest, worse on exertion |
| | | | | ← Total |

## OVERALL GUT HEALTH

| | | |
|---|---|---|
| ☐ Yes | ☐ No | Do you live in a polluted environment? |
| ☐ Yes | ☐ No | Memory problems and poor concentration |
| ☐ Yes | ☐ No | Frequent colds or infections |
| ☐ Yes | ☐ No | High blood pressure |
| ☐ Yes | ☐ No | Floss at least once a day? |
| ☐ Yes | ☐ No | Did mother take antibiotics/pregnant? |
| ☐ Yes | ☐ No | Did mother take steroids/pregnant? |
| ☐ Yes | ☐ No | Were you born by C-Section? |
| ☐ Yes | ☐ No | Were you breastfed? How long? |
| ☐ Yes | ☐ No | Steroid meds for more than one week? |
| ☐ Yes | ☐ No | Antibiotics at least once every 2-3 yrs? |
| ☐ Yes | ☐ No | Acid-blocking drugs (digestion or reflux) |
| ☐ Yes | ☐ No | Require laxative at least once a month? |
| ☐ Yes | ☐ No | Do you have food allergies? |
| ☐ Yes | ☐ No | Chemical sensitivity in everyday product? |
| ☐ Yes | ☐ No | Diagnosed with an autoimmune disease? |
| ☐ Yes | ☐ No | More than 20 pounds overweight? |

## THYROID GLAND

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Difficulty losing weight |
| 0 | 1 | 2 | 3 | Loss of outer 1/3 eyebrows |
| 0 | 1 | 2 | 3 | Mentally Sluggish |
| 0 | 1 | 2 | 3 | Cold hands and feet |
| 0 | 1 | 2 | 3 | Hair loss |
| 0 | 1 | 2 | 3 | Easily fatigued |
| 0 | 1 | 2 | 3 | Seasonal sadness |
| 0 | 1 | 2 | 3 | Low body temperature |
| 0 | 1 | 2 | 3 | Sensitive to iodine |
| 0 | 1 | 2 | 3 | Fast pulse at rest |
| 0 | 1 | 2 | 3 | Nervousness |
| 0 | 1 | 2 | 3 | Sensitivity to cold |
| 0 | 1 | 2 | 3 | Intolerant to heat |
| 0 | 1 | 2 | 3 | Flush easily |
| 0 | 1 | 2 | 3 | Heart palpitations |
| | | | | ← Total |

## CHILDHOOD ILLNESS/INJURIES (Ages 0-18 yrs.)

Please check all that apply

| | | | |
|---|---|---|---|
| ☐ | Fully vaccinated? | ☐ Yes | ☐ No |
| ☐ | Frequent ear infections? | ☐ Yes | ☐ No |
| ☐ | Frequent throat infections? | ☐ Yes | ☐ No |

| | | | |
|---|---|---|---|
| ☐ | Meningitis | | |
| ☐ | Asthma | | |
| ☐ | Cancer | | |
| ☐ | Seizures/Epilepsy | | |
| ☐ | Lyme Disease | | |
| ☐ | ☐ Pneumonia | ☐ Bronchitis | ☐ Lung Issues |
| ☐ | Diabetes | Type 1: ☐ | Type 2: ☐ |
| ☐ | ☐ Measles | ☐ Chicken Pox | |
| ☐ | ☐ Mononucleosis (Mono) | ☐ Epstein Barr Virus (EBV) | |
| ☐ | ☐ Pinworms | ☐ Other Parasites | |
| ☐ | ☐ Anxiety | ☐ Depression | |
| ☐ | ☐ Cutting | ☐ Anorexia | ☐ Self-Harm |
| ☐ | ☐ Eating Disorder | ☐ Anorexia | ☐ Bulimia |

## COVID

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| If vaccinated, what company or companies did you use? | | | | | | | | | | |
| ☐ Yes | ☐ No | 1 shot | Date Received: | Side effects: | | | | | | |
| ☐ Yes | ☐ No | 2 shots | Date Received: | Side effects: | | | | | | |
| ☐ Yes | ☐ No | Booster | Date Received: | Side effects: | | | | | | |
| ☐ Yes | ☐ No | Any side effects to the vaccination/s? | | | | | | | | |
| ☐ Yes | ☐ No | If side effects, what were they | | | | | | | | |
| Did you take a COVID test? | ☐ Yes | ☐ No | | POSITIVE | | NEGATIVE | | BOTH | | |
| Date of test(s)? | | | | | | | | | | |
| How were you tested? | | | | | | | | | | |
| ☐ Yes | ☐ No | Did you have to go into the hospital due to COVID? | | | | | | | | |
| If yes, what was the diagnosis? | | | | | | | | | | |
| How long did you stay in the hospital? | | | | | | | | | | |
| What supplements were you on in the hospital? | | | | | | | | | | |
| | | | | | | | | | | |
| What medications were you on in the hospital? | | | | | | | | | | |
| | | | | | | | | | | |
| What blood tests did you take? | | Iron level | | Liver health | | Infection | | Clotting | | |
| What scans did you have? | MRI? | | | CT? | | | | | | |
| What were the results? | | | | | | | | | | |
| ☐ Yes | ☐ No | X-Rays? | | | | | | | | |
| What medications are you taking, or did you have to take for COVID? | | | | | | | | | | |
| ☐ Yes | ☐ No | Steroids | ☐ Yes | ☐ No | Antibiotics | ☐ Yes | ☐ No | Anticlotting | | |
| ☐ Yes | ☐ No | Antiplatelets | ☐ Yes | ☐ No | Blood pressure | ☐ Yes | ☐ No | Oxygen | | |
| Other? | | | | | | | | | | |
| How many blood clots did you get? (ZERO, if none) | | | | | | | | | | |
| Medication taking for it? | | | | | | | | | | |

## RECOVERY

| |
|---|
| When did symptoms begin for COVID? |
| Are you completely recovered from all symptoms from COVID? |
| If not, which ones are you still suffering from? |
| If you are, how long did it take you to feel completely recovered? |
| Are you back to your regular routine? |

## OTHER

| |
|---|
| |
| |
| |
| |
| |

| COVID: SYMPTOMS | | | | | | |
|---|---|---|---|---|---|---|
| 1. *Blood Pressure* | Low? | | High? | | Is this normal for you? | |
| 2. *Chills* | With pain? | | Without pain? | | With needles? | |
| 3. *Coughing* | How much? | | Can you walk without coughing? | | Can you run without coughing? | |
| | | | | | | |
| | Can you talk without coughing? | | Can you exercise without coughing? | | Can you get up after going to the bathroom without coughing? | |
| | | | | | | |
| 4. *Digestive Upset* | Nausea? | | Vomiting? | | How many days? | |
| | Diarrhea? | | How many days? | | | |
| 5. *Extreme fatigue* | How much are you sleeping per day? | | | | | |
| | Are you able to sleep laying down or do you have to sleep sitting up? | | | | | |
| | Is coughing keeping you awake and interfering with your sleep? | | | | | |
| 6. *Fever* | What temp? | | For how many days? | | | |
| 7. *Hair loss* | How many days? | | How much hair loss? | | | |
| 8. *Joint Pain* | Which joints? | | | | | |
| | Level of pain? | | How many days? | | | |
| 9. *Painful Urination* | How many days? | | UTI? | | | |
| | Antibiotic Treatment? | | Name of medication? | | | |
| | How many days? | | Side effects from medication? | | | |
| 10. *Rashes* | Where? | | How many? | | | |
| 11. *Senses* | Did you lose your sense of taste? | | Can you taste now? | | | |
| | Did you lose your sense of smell? | | Can you smell now? | | | |
| 12. *Shaking* | Where? | | When? | | | |
| | Does anything help the shaking? | | | | | |
| 13. *Supplements* | What dosages? | | For how long? | | | |
| 14. *Trouble Breathing* | Are you short of breath? | | | | | |
| | What causes you to get out of breath? | | | | | |
| | | | | | | |
| | Have you checked your oxygen level? | | What is your oxygen level at rest? | | | |
| | While walking? | | While sitting? | | | |
| | Does your oxygen level stay over 92 or fall below 92? | | | | | |
| | Do you have tingling anywhere in your body (neck, shoulders, arms, hands, feet, legs)? | | | | | |
| | | | | | | |
| | Do you feel like any part of your body is disconnected? Care to explain? | | | | | |
| | | | | | | |
| | | | | | | |

## MENTAL/EMOTIONAL HEALTH

Please mark the following by placing the appropriate letter (R, S, or F) in all the boxes that apply to you.

| R = Rare | | S = Sometimes | | F = Frequently | |
|---|---|---|---|---|---|
| | Aggressive | | Greedy | | Restless |
| | Anger | | Grief | | Seeker of knowledge |
| | Anxiety | | Inability to concentrate | | Seeks power, prestige, position |
| | Attachment | | Indecisive and unsure | | Self-disciplined |
| | Avoids confrontations | | Insecurity | | Sentimental, soft-hearted |
| | Bold, domineering | | Intolerant | | Sex drive |
| | Boredom | | Irritable | | Sharp tongued |
| | Calm | | Judgmental | | Sloppy |
| | Cannot shut off my mind | | Laziness | | Slow |
| | Compassionate | | Loneliness | | Spacey |
| | Confident | | Mental lethargy | | Spontaneous |
| | Confused | | Nervousness | | Stays distant and aloof |
| | Contentment | | Optimistic | | Steadfast and unwavering |
| | Depression | | Outgoing, friendly | | Straightforward, direct |
| | Detached from feelings | | Patient | | Stress |
| | Difficulty speaking up | | Peaceful | | Stubborn |
| | Easygoing | | Perfectionist | | Success/failure mind set |
| | Enthusiastic | | Practical | | Suicidal tendencies |
| | Envious | | Procrastinate, hesitate | | Takes time for self-care |
| | Expresses joy | | Realistic, practical | | Talkative, excitable |
| | Fearful | | Repetitive thinking | | Vengeful |
| | Forgetful | | Resentful | | Worrier |
| | Forgiving | | Resistant to change | | |

## DIET

| Specific Food | Quantity | | | Per Day/Week/Month |
|---|---|---|---|---|
| Coffee | | | Cups | ☐ Day ☐ Week ☐ Month |
| Fruit Drinks | | | Can(s) | ☐ Day ☐ Week ☐ Month |
| Soda, Diet Soda (or any variation) | | | Can(s) | ☐ Day ☐ Week ☐ Month |
| Candy | | | Time(s) | ☐ Day ☐ Week ☐ Month |
| Chocolate | | | Time(s) | ☐ Day ☐ Week ☐ Month |
| Alcohol | | | Drink(s) | ☐ Day ☐ Week ☐ Month |
| Fast Food | | | Time(s) | ☐ Day ☐ Week ☐ Month |
| Dairy: Milk/Cheese/Cream/Custard/Yogurt/IC | | | Time(s) | ☐ Day ☐ Week ☐ Month |
| Fried Food | | | Time(s) | ☐ Day ☐ Week ☐ Month |
| Margarine/Tub Spreads | | | Time(s) | ☐ Day ☐ Week ☐ Month |

## CURRENT DIET (Give average examples of your daily diet)

| | Breakfast: | Lunch: | Dinner: | Snacks: |
|---|---|---|---|---|
| Day 1 | | | | |
| | | | | |
| Day 2 | | | | |
| | | | | |
| Day 3 | | | | |
| | | | | |
| Day 4 | | | | |
| | | | | |
| Day 5 | | | | |
| | | | | |

| | | | |
|---|---|---|---|
| How many meals do you eat per day? | | | |
| Do you skip any meals? | | If "yes," which one(s)? | |
| How often do you eat out? | | | |
| List some of your most common food items: | | | |
| | | | |
| Lunch: | | | |
| Dinner: | | | |
| Snacks: | | | |

**How serious are you about improving your health?**

| | | | | | |
|---|---|---|---|---|---|
| Very Serious | | Serious | | Other | |

**What are you willing to do to improve your health?**

| | | | | | |
|---|---|---|---|---|---|
| TAKE SUPPLEMENTS | | EXERCISE | | WHATEVER IT TAKES! | |

HEALTH COACH'S COMMENT:

## OTHER HEALTHCARE PRACTITIONER'S REMARKS

From Page 1, if you are currently receiving treatment from other healthcare practitioners, what did you go for? What tests were performed? What were the results? Anything else?

| Date | Remarks |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## SUPPLEMENTAL INFORMATION | CLIENT'S CHOICE

If applicable, what page are you providing supplemental information?

| Date | Remarks |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## SIGNATURE

Thank you for completing this intake form. Your signature means you agree that all the information you provided is true to the best of your knowledge. You also understand that omitting or providing incorrect information, whether intentionally or unintentionally, will not be beneficial to the health practitioner's suggestions nor the expected results for both parties.

| | |
|---|---|
| | |
| Signature | Date |