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:	
Relationship Status:					
Children:		If so, their ages:			
Pets: ☐ Yes	☐ No	_____ How many?		Type(s):	
Height:		Weight:		Weight One Year Ago:	
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?	
What are your health goals?	

1.		2.	
3.		4.	
5.		6.	
7.		8.	
9.		10.	

HEALTH HISTORY: List any surgeries, major illnesses, 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 and Anxiety	Type		Relation	
☐	Alzheimer's	Type		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 space below to explain, check corresponding number on left
				← Total

CURRENT RX, SUPPLEMENTS, ETC.

Name	Dosages per day unless indicated

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) ☐ Cholesterol ☐ Glucogenesis (Insulin Resistance, Diabetes)
Calcification	☐ Arthritis ☐ Cataract ☐ Bone Spurs
Peripheral Circulation and Brain Health	☐ Dementia ☐ Alzheimer's ☐ Reynaud's

CURRENT RX, SUPPLEMENTS, ETC.

Name	Dosages per day unless indicated

*

Revised: 05/2021

Please circle all that apply. Follow key below.

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WOMEN'S PROBLEMS

0	1	2	3	Painful menstrual cycle
0	1	2	3	Mood swings around cycle
0	1	2	3	Painful breasts at cycle
0	1	2	3	Irregular cycles
0	1	2	3	Heavy menstrual flow
0	1	2	3	Acne at menstrual cycle
0	1	2	3	Yeast infections
0	1	2	3	Endometriosis
0	1	2	3	Uterine fibroids
0	1	2	3	Fibrocystic breasts
0	1	2	3	Hot flashes
0	1	2	3	Vaginal itchiness
0	1	2	3	Vaginal discharge
0	1	2	3	Night sweats
0	1	2	3	Menopausal symptoms
				← Total

SMALL INTESTINE

0	1	2	3	Food allergies
0	1	2	3	Bloating after eating
0	1	2	3	Airborne allergies
0	1	2	3	Wheat or gluten sensitivity
0	1	2	3	Dairy sensitivity
0	1	2	3	Sinus congestion
0	1	2	3	Craves bread/pasta
0	1	2	3	Pulse speeds after eating
0	1	2	3	Nightmares
0	1	2	3	Feel spacy or unreal
0	1	2	3	Alternating diarrhea/constipations
0	1	2	3	Hives
				← Total

LARGE INTESTINE

0	1	2	3	Skip days between bowels movements
0	1	2	3	Stools hard or difficult to pass
0	1	2	3	Cramping on lower abdomen
0	1	2	3	Mucus in stool
0	1	2	3	IBS or colitis
0	1	2	3	Yeast infections
0	1	2	3	Nail fungus or athletes' foot
0	1	2	3	Dark circles under eyes
0	1	2	3	History of parasites
				← Total

MEN'S PROBLEMS

0	1	2	3	Prostate problems
0	1	2	3	Decreased libido
0	1	2	3	Urination difficult
0	1	2	3	Pain or burning with urination
0	1	2	3	Fatigue
0	1	2	3	Pain on inside of legs/heels
0	1	2	3	Feeling of incomplete bowel
				← Total

STOMACH

0	1	2	3	Heartburn or Acid Reflux
0	1	2	3	Burping or Gas after eating
0	1	2	3	Bloating after eating
0	1	2	3	Bad Breath
0	1	2	3	Sweat has a strong odor
0	1	2	3	Feel better if I do not eat
0	1	2	3	Sleepy after meals
0	1	2	3	Burning pain in stomach
0	1	2	3	Fingernails chip/break/peel
0	1	2	3	Anemia Unresponsive to iron
0	1	2	3	Stomach pain or cramps
0	1	2	3	Diarrhea, chronic
0	1	2	3	Diarrhea after meals
0	1	2	3	Black or dark stool
0	1	2	3	Undigested food in stool
				← Total

LIVER

				☐ MTHFR Positive
0	1	2	3	Age or "Liver" spots
0	1	2	3	Easily intoxicated
0	1	2	3	Gallbladder attacks or stones
0	1	2	3	Greasy foods upset stomach
0	1	2	3	Headache over eyes
0	1	2	3	Hemorrhoids or varicose veins
0	1	2	3	Insomnia (Melatonin deficiency)
0	1	2	3	Nausea
0	1	2	3	Motion sickness
0	1	2	3	Pain between shoulder blades
0	1	2	3	Pain under right rib cage
0	1	2	3	Sensitivity to perfumes/chemicals/etc.
0	1	2	3	Skin rashes/acne/eczema
				← Total

Please circle all that apply. Follow key below.

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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

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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: how many times/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 for < a month
☐ Yes	☐ No	Steroid meds for > 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

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? Circle one or answer "yes" or "no" in box.			
Very Serious		Serious		Other	
What are you willing to do to improve your health? Circle one or answer "yes" or "no" in box.			
TAKE SUPPLEMENTS		EXERCISE		WHATEVER IT TAKES!	
HEALTH COACH'S COMMENT: Incorporate a highly practical regimen of six essential keys: prebiotics, probiotics, fermented foods, low-carb foods, gluten-free foods, and healthy fats.				