The Intake Form

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work #: _____Cell #: _____
Occupation: _____ Hours of work per week:_____
Age: ____ Birth Date: _____ Current weight: _____ Weight one year ago:_____
Email address: _____ Relationship status: _____
Children?:_____ Ages:_____ Pets: _____
How did you hear about us? _____Would you like to receive our newsletter? _____

Present Compiaints: List the your main health problems:

1._____When did it start? _____
2._____When did it start?_____
3._____When did it start? _____
4. _____ When did it start? _____
5._____When did it start? _____

At what point in your life did you feel best?_____
_____
_____

What are your health goals: _____
_____
_____

Medications or nutritional supplements you are currently taking: List them:
_____
_____
_____

Section 1–

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

1. 0 1 2 3 Heartburn or Acid Reflux
2. 0 1 2 3 Burping or Gas after eating
3. 0 1 2 3 Bloating after eating
4. 0 1 2 3 Bad breath
5. 0 1 2 3 Sweat has a strong odor
6. 0 1 2 3 Feel better if I don't eat
7. 0 1 2 3 Sleepy after meals
8. 0 1 2 3 Burning pain in stomach
9. 0 1 2 3 Fingernails chip, break, peel
10. 0 1 2 3 Anemia unresponsive to iron
11. 0 1 2 3 Stomach pain or cramps
12. 0 1 2 3 Diarrhea, chronic
13. 0 1 2 3 Diarrhea after meals
14. 0 1 2 3 Black or dark stool
15. 0 1 2 3 Undigested food in stool

how many days between bowel movements

Section 2–

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

16. 0 1 2 3 Skip days between bowel movm.
17. 0 1 2 3 Stools hard or difficult to pass
18. 0 1 2 3 Cramping on lower abdomen
19. 0 1 2 3 Blood in stool
20. 0 1 2 3 Mucus in stool
21. 0 1 2 3 IBS or colitis
22. 0 1 2 3 Yeast Infections
23. 0 1 2 3 Nail fungus or athletes foot
24. 0 1 2 3 Dark circles under eyes
25. 0 1 2 3 History of parasites
26. 0 1 2 3 Coated tongue
27. 0 1 2 3 Anus itches
28. 0 1 2 3 Constipation
29. 0 1 2 3 Stools are loose
30. 0 1 2 3 Bad smelling gas

Section 3–

31. 0 1 2 3 Food allergies
32. 0 1 2 3 Bloating after eating
33. 0 1 2 3 Airborne allergies
34. 0 1 2 3 Wheat or gluten sensitivity
35. 0 1 2 3 Dairy sensitivity
36. 0 1 2 3 Sinus congestion
37. 0 1 2 3 Craves bread and pasta
38. 0 1 2 3 Pulse speeds after eating
39. 0 1 2 3 Nightmares
40. 0 1 2 3 Feel spacy or unreal
41. 0 1 2 3 Alternating diarrhea/ constipation
42. 0 1 2 3 Hives

Section 4–

43. 0 1 2 3 Nausea
44. 0 1 2 3 Pain between shoulder blades
45. 0 1 2 3 Skin rashes, acne, eczema, etc
46. 0 1 2 3 Age or "Liver" spots
47. 0 1 2 3 Greasy foods upset stomach
48. 0 1 2 3 Gallbladder attacks or stones
49. 0 1 2 3 Motion sickness
50. 0 1 2 3 Headache over eyes
51. 0 1 2 3 Easily intoxicated
52. 0 1 2 3 Hemorrhoids or varicose veins
53. 0 1 2 3 Sensitivity to perfumes or chemicals, etc...
54. 0 1 2 3 Pain under right rib cage
55. 0 1 2 3 Insomnia

how many hours on average per night

Section 5–

56. 0 1 2 3 Carpal Tunnel Syndrome
57. 0 1 2 3 Osteoporosis or Osteopenia
58. 0 1 2 3 Legs or foot cramps at rest
59. 0 1 2 3 Pain or swelling in joints
60. 0 1 2 3 Bursitis or tendonitis
61. 0 1 2 3 Joints pop or crack
62. 0 1 2 3 White spots on fingernails
63. 0 1 2 3 Decreased taste or smell

Section 6–

64. 0 1 2 3 Intense Fatigue
65. 0 1 2 3 Brain Fog
66. 0 1 2 3 Memory loss-short & long term
67. 0 1 2 3 Pain or swelling in joints
68. 0 1 2 3 Stiff joints in morning
69. 0 1 2 3 Muscle twitching
70. 0 1 2 3 Unexplained fevers
71. 0 1 2 3 Headaches/Migraines
72. 0 1 2 3 Poor concentration
73. 0 1 2 3 Sore soles of feet in morning

Section 7–

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

74. 0 1 2 3 Body jerks as falling asleep
75. 0 1 2 3 Restless leg syndrome
76. 0 1 2 3 Small bumps on back of arms
77. 0 1 2 3 Heart races
78. 0 1 2 3 Worrier, anxious
79. 0 1 2 3 Nosebleeds
80. 0 1 2 3 Bruise easily
81. 0 1 2 3 Gums bleed easily
82. 0 1 2 3 Depressed regularly
83. 0 1 2 3 Numbness or tingling in body
84. 0 1 2 3 Loss of muscle tone

Section 8–

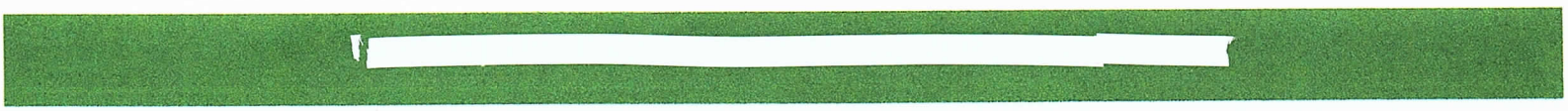
85. 0 1 2 3 Difficulty falling asleep
86. 0 1 2 3 Slow starter in the morning
87. 0 1 2 3 Become dizzy when standing suddenly
88. 0 1 2 3 Difficulty holding chiropractic adjustments
89. 0 1 2 3 Arthritis
90. 0 1 2 3 Crave salty food
91. 0 1 2 3 Headache after exercise
92. 0 1 2 3 Chronic low back pain
93. 0 1 2 3 Clench or grind teeth
94. 0 1 2 3 Perspire too easily
95. 0 1 2 3 Hives
96. 0 1 2 3 Bright light hurts eyes
97. 0 1 2 3 Slow recovery from stress

Section 9–

98. 0 1 2 3 Difficulty losing weight
99. 0 1 2 3 Loss of outer 1/3 eyebrows
100. 0 1 2 3 Mentally sluggish
101. 0 1 2 3 Cold hands and feet
102. 0 1 2 3 Hair loss
103. 0 1 2 3 Easily fatigued
104. 0 1 2 3 Seasonal sadness
105. 0 1 2 3 Low body temperature
106. 0 1 2 3 Sensitive to iodine
107. 0 1 2 3 Fast pulse at rest
108. 0 1 2 3 Nervousness
109. 0 1 2 3 Sensitivity to cold
110. 0 1 2 3 Intolerant to heat
111. 0 1 2 3 Flush easily
112. 0 1 2 3 Heart palpitations

Section 10–

113. 0 1 2 3 Crave sweets
114. 0 1 2 3 Awaken during night, hard to fall back asleep
115. 0 1 2 3 Excessive appetite
116. 0 1 2 3 Crave coffee or sugar in afternoon
117. 0 1 2 3 Headache if meals are delayed
118. 0 1 2 3 Get shaky or weak if hungry
119. 0 1 2 3 Sleepy in afternoon
120. 0 1 2 3 Fatigue relieved by eating
121. 0 1 2 3 Afternoon headaches
122. 0 1 2 3 Irritable before me



Section 11– [Womens Problems]

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

126. 0 1 2 3 Painful menstrual cycle
127. 0 1 2 3 Mood swings around cycle
128. 0 1 2 3 Painful breasts at cycle
129. 0 1 2 3 Irregular cycles
130. 0 1 2 3 Heavy menstrual flow
131. 0 1 2 3 Acne at menstrual cycle
132. 0 1 2 3 Yeast Infections
133. 0 1 2 3 Endometriosis
134. 0 1 2 3 Uterine fibroids
135. 0 1 2 3 Fibrocystic breasts
136. 0 1 2 3 Hot flashes
137. 0 1 2 3 Vaginal itchiness
138. 0 1 2 3 Vaginal discharge
139. 0 1 2 3 Night sweats
140. 0 1 2 3 Menopausal symptoms

Section 12– [Mens Problems]

141. 0 1 2 3 Prostate problems
142. 0 1 2 3 Decreased libido
143. 0 1 2 3 Urination difficult
144. 0 1 2 3 Pain or burning with urination
145. 0 1 2 3 Fatigue
146. 0 1 2 3 Pain on inside of legs or heels
147. 0 1 2 3 Feeling of incomplete bowel

Section 13–

148. 0 1 2 3 Shortness of breath with moderate exertion
149. 0 1 2 3 Opens windows in closed room
150. 0 1 2 3 Sigh frequently
151. 0 1 2 3 Bruise easily
152. 0 1 2 3 Ankles swell at end of day
153. 0 1 2 3 Muscle cramps during exercise
154. 0 1 2 3 Hands and feet go to sleep
155. 0 1 2 3 Dull pain in chest, worse on exertion

Section 14–

157. 0 1 2 3 Pain upon urination
158. 0 1 2 3 Frequent bladder infections
159. 0 1 2 3 Cloudy, bloody, or dark urine
160. 0 1 2 3 Urine has strong odor
161. 0 1 2 3 History of kidney stones
162. 0 1 2 3 Dribbling urination
163. 0 1 2 3 Pain in low back
164. 0 1 2 3 Frequent urination

Section 15–

165. 0 1 2 3 Catch colds/flu easily
166. 0 1 2 3 Runny or drippy nose
167. 0 1 2 3 Swollen lymph nodes
168. 0 1 2 3 Gets boils, cysts, styes
169. 0 1 2 3 Poor wound healing
170. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles or Chronic Fatigue

How is your Diet:

- ❑ Coffee: _____ cups per: ❑Day ❑Week ❑Month
- ❑ Soft drinks: ____ can per: ❑Day ❑Week ❑Month
- ❑ Diet soda: _____ can per: ❑Day ❑Week ❑Month
- ❑ Candy: _____ times per: ❑Day ❑Week ❑Month
- ❑ Chocolate: ____times per: ❑Day ❑Week ❑Month
- ❑ Alcohol: _____ times per: ❑Day ❑Week ❑Month
- ❑ Fast food: _____ times per: ❑Day ❑Week ❑Month
- ❑ Milk/cheese: ____ times per: ❑Day ❑Week ❑Month
- ❑ Fried food: _____ times per: ❑Day ❑Week ❑Month
- ❑ Margarine or tub spreads

Current Diet Information: Give some examples of foods you typically eat:

Breakfast: _____

Lunch: _____

Snacks: _____

Dinner: _____

Liquids: _____

How many meals do you eat per day? _____What meals do you skip? _____

Do you cook? _____ What percentage of meals are home-cooked? _____

Health History:

List any major illnesses with approximate dates:

Illness:	Date:	Recovered?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any family history of serious illnesses?

❑ Cancer ❑ Heart Disease ❑ Diabetes ❑ Other: _____

Please list any surgeries, operations, traumas, car accidents, etc...:

_____

_____

What are your Hobbies: _____

What would you like to do once you get healthier that you can't do now? _____

_____

Commitment Level: **How serious are you about improving your health?**

❑ Very serious ❑ Serious ❑ Other: _____

What are you willing to do to improve your health?

❑ Take supplements only ❑ Exercise only ❑ Whatever it takes!!

[pages 10-13 are not included in this excerpt]

IF YOU HAVE A MAJOR HEALTH COMPLAINT(S), HAVE YOU EVER RECEIVED CARE FOR THIS CONDITION BEFORE? YES / NO

IF YES, WHAT & WHEN?_____

WHAT WERE THE RESULTS?_____

WHAT MAKES IT BETTER?_____ WORSE?_____

STRESS:

PLEASE LIST ANY PHYSICAL OR EMOTIONAL STRESSORS / CAUSES OF ANXIETY IN YOUR LIFE:

PLEASE LIST ANY SIGNIFICAN TRAUMAS (PHYSICAL OR EMOTIONAL), INCLUDING APPROXIMATE DATE:

AS BEST YOU CAN, PLEASE DESCRIBE ANY EMOTIONAL ISSUES YOU'RE FACING RIGHT NOW OR PARTICULAR BEHAVIORAL PATTERNS ABOUT YOURSELF THAT YOU WOULD LIKE TO CHANGE:

HOW DO YOU COPE WITH STRESS?

DO YOU HAVE A DAILY PRACTICE OF SELF-CARE (I.E. JOURNALING, MEDITATION, PRAYER, DEEP BREATHING, STRETCHING)? PLEASE DESCRIBE:

PLEASE RATE THE FOLLOWING ON A SCALE OF 1 - 10, 10 BEING THE BEST AND 1 BEING THE WORST.

	On a scale of 1 – 10...
Your physical health	
Your mental / emotional health	
Your spiritual health	

PLEASE LIST HOW MUCH OF THE FOLLOWING YOU GET PER DAY:

SLEEP (IN HOURS)? _____

WATER (IN OUNCES)? _____

EXERCISE (IN MINUTES)? _____

REST / RELAXATION / RECREATION (IN MINUTES / HOURS)? _____

SUNLIGHT / FRESH AIR / TIME IN NATURE (IN MINUTES / HOURS)? _____