NEW CLIENT INTAKE FORM

Please return this form 72 hours prior to your appointment

Client Name: _____

Date: _____ Appointment Date: _____

Please list your primary questions or concerns for discussion in our appointment, so that we can be certain to address these in our consultation.

Client Health Information

Please write as neatly as possible!

Name			Email address	
Address				Phone
				Date
Sex	Date of Birth	Height	Weight	Blood Type (if known)

Name/Address/Phone number of physician

Referred by

What is the main reason you are seeking nutritional counseling?

Please describe any current illnesses

Name and date of any prescription medications used (if currently on medications please include strength and dose):

How many glasses of water do you drink daily? _____

What is your stress level on a scale of 1 – 10 (10 is high) _____

How do you rate your cooking ability? (1=don't cook at all, 5=very comfortable in the kitchen) 1 2 3 4 5

Please describe what you eat on a typical day. This is very important, so please include all meals and snacks. Also, include any dietary restrictions (vegetarian, religious restrictions, etc.)

List any food allergies or sensitivities. If it is a food sensitivity based on an IgG test, put the date of the test and the number corresponding to the foods reaction (ex. +1, +2,..)

Bowel movements:

How often: _____ times per day or every _____ days

Color: light dark unsure (circle one)

Consistency: hard/dry firm/moist loose watery/diarrhea (circle one)

Please circle any of the following that apply:

hyperactive

low energy

difficulty concentrating

sleep problems (please describe) _____

sensory issues (please describe) _____

white spots on nails

dandruff/thinning hair/dry hair

dry skin/rashes/eczema

excess ear wax

nose bleeds

bleeding gums (when brushing teeth)

poor night vision

sun light hurt eyes

cold hands/feet

excessive urination

tired after eating

shake, light headed or anxious when a meal is missed

abdominal bloating

Anxiety/
depression

Hormonal issues/ PMS (please be specific)

other (please describe)_____

Describe current daily/weekly exercise:

What diseases/conditions run in the family

Is there anything else about you that we should know?

If you are currently on any supplements, please list them below (be specific..brand etc.).

Feel free to attach another page if you need more room.

If you have any recent blood work or other tests, please attach it with this questionnaire.