

Client Intake Form (Confidential)

Name: _____ Date: _____

Address: _____

Referred By: _____

Telephone: _____ Wk/Cell: _____

Date of Birth: _____ Time of Birth: _____ Place of Birth _____

List Concerns:

Nutrition (Consumed Daily):

- | | | | |
|---------------------------------|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> dairy | <input type="checkbox"/> breads/pasta | <input type="checkbox"/> vegetables | <input type="checkbox"/> essential fats |
| <input type="checkbox"/> fruits | <input type="checkbox"/> meat | <input type="checkbox"/> whole grains | <input type="checkbox"/> supplements |

Please check:

- Pregnant
 Pacemaker

Bowel Movements:

___ per day (ideally, 12 hours after each meal,
or
___ per week or **at least**, two times per day)

Sleep:

wake ___ times/night
 wake-up tired

Medication(s):

SOC:

1. Number of organs removed (including tonsils, adenoids, appendix, and teeth)		11. Personal Stress 1-10	
2. Number of prescribed medications		12. Sugar products used per day	
3. Number of cigarettes smoked per day		13. Exercise sessions per week, 20 minutes or more	
4. Steroid drugs used in last 12 months (incl. the pill, inhalers and cortisone creams)		14. Alcohol consumed per day	
5. Number of metal dental fillings		15. Coffee/Tea (caffeine) per day	
6. Number of recreational drugs used in last month		16. Extreme toxic exposures in last year (x-rays, insecticides, chemicals)	
7. Known allergies by groups, i.e., food, animals, etc. (wheat + strawberries=1)		17. Major injuries/trauma that still effect you today	
8. Unresolved mental conflicts		18. Major infections, past and present	
9. Take responsibility for own health 1-10		19. Glasses of water per day	
10. % fat in diet (2=ideal, 4=average)		20. Kilos overweight	

Additional comments:
