DATE_____

CLIENT INTAKE FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME: ☐M ☐F		DOB:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE:	EMAIL:		

MARTIAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

REASON FOR VISIT:

PRIMARY HEALTH GOALS:

LIFESTYLE

Occupation:	Length of time:	
Hours worked per week:	Vacation days per year:	Travel involved? ☐Y ☐N
Does your schedule vary? ☐Y ☐N	Do you enjoy your work? ☐Y ☐N	

What are the physical demands of your work (standing, sitting, computer use, heavy lifting, etc.)

Exercise - type, frequency, how long have you been doing this type?

Hours of sleep per night	Usual bedtime	Usual rise time
Do you ever have traumatic dreams ☐Y ☐N	If so, please explain	

Check all that apply ☐Work at night ☐Disturbed sleep ☐Insomnia ☐Sleep apnea ☐Trouble falling asleep ☐Trouble staying asleep ☐Use sleep medications ☐Feel rested when waking in the morning

Do you currently smoke cigarettes? ☐Y ☐N	If so, how many per day?

If you previously smoked, when did you quit?

Do you drink alcohol? ☐Y ☐N	If so, how often and what kind?

Have you ever had problems with alcohol or been in a recovery program? If so, please explain

Are you currently taking any recreational drugs? ☐Y ☐N	If so, what kind(s) and how often?
Do you use electronic devices? ☐Y ☐N	If so, what kind(s) and how often?

DIET

For each item, please fill in using the following scale:
F – Frequently consume (daily or more)
O – Occasionally consume (a few times a week)
I – Irregularly consume, generally less than once a week
N – Never consume (or very infrequently)

___Baked Goods	___Eggs	___Juice	___Seafood
___Beef	___Fast Food	___Milk	___Seaweed
___Beer	___Fermented Foods	___Nut butters	___Soda
___Black Tea	___Fish	___Nuts/seeds	___Sweets
___Bread	___Fried foods	___Organic foods	___Tea
___Cheese	___Fruit	___Pork	___Vegetables cooked
___Chicken	___Grains	___Potato chips	___Vegetables raw
___Coffee	___Green tea	___Refined flour	___Water
___Eat Out	___Herbal tea	___Refined sugar	

Do you have any dietary restrictions or are on a special diet?

If so, how long have you been on this diet?

Do you have any cravings (sugar, salt, spicy, etc)

How much water do you drink a day?

MEDICATIONS AND SUPPLEMENTS

Prescription Medications	Currently Taking or Apprx dates taken	Dose, Form, Frequency	Related Condition	Side effects experienced

Over-the-Counter Medications	Currently Taking or Apprx dates taken	Dose, Form, Frequency	Related Condition	Side effects experienced
Vitamin/Mineral Supplements and Nutritional Drinks	Currently Taking or Apprx dates taken	Dose, Form, Frequency	Related Condition	Side effects experienced
Herbal Supplements	Currently Taking or Apprx dates taken	Dose, Form, Frequency	Related Condition	Side effects experienced

FAMILY HISTORY

Has anyone in your immediate, biological family (parents, grandparents, siblings, children) ever been diagnosed with the following? Check all that apply.

☐Cancer/Type_____ ☐Diabetes ☐Heart disease ☐High blood pressure
☐Thyroid disease ☐Mental Health Issues ☐Seizures ☐Alcoholism
☐Hepatitis ☐Other_____

MEDICAL HISTORY

Place of Birth:

Have you been diagnosed with any of the following:

☐Cancer ☐Diabetes ☐Hepatitis ☐High Blood Pressure ☐Seizures ☐Thyroid disease
☐Other_____

Surgeries (including cosmetic and dental). Provide date for each.

Hospitalizations? Provide date and reason for each.

Allergies (drugs, chemical foods)	What, if anything, do you take for them?

Major trauma (concussion, accidents, physical, or emotional trauma

HEALTH HISTORY

CHECK ALL THAT APPLY. PLEASE ELABORATE IN COMMENT/TREATMENT SECTION UNDER EACH CATEGORY

CARDIOVASCULAR

☐Angina ☐Cardiac arrest ☐Heart attack ☐Low blood pressure ☐Stroke
☐Arrhythmias ☐Chest pains ☐Heart flutter ☐Mitral valve prolapse ☐Varicose veins
☐Arteriosclerosis ☐Congenital deformities ☐Heart irregularities ☐Palpitation
☐Bruise easily ☐Congestive heart failure ☐Heart murmur ☐Pericarditis
☐Bleed easily ☐Edema ☐High blood pressure ☐Poor circulation
☐Capillary fragility ☐Fast heart beat ☐Ischemia ☐Slow heart beat
☐Other_____

Comments/Treatments_____

DENTAL/MOUTH

☐Cavities ☐Gum disease ☐Sensitivity
☐Dentures/false teeth ☐Loose teeth ☐Sore gums
☐Difficulty swallowing ☐Painful/tight jaw ☐TMJ
☐Dry mouth ☐Root canal
☐Other_____

Comments/Treatments_____

DIGESTION

☐Anorexia ☐Changes in bowel habits ☐Eating disorders ☐Hemorrhoids ☐Nausea
☐Bad breath ☐Crohn's disease ☐Gas ☐Indigestion ☐Pain after eating
☐Belching ☐Constipation ☐Gastric bypass ☐Irritable bowel syndrome ☐Parasites
☐Bloating after meals ☐Diarrhea ☐Gastric reflux ☐Large appetite ☐Ulcer/Colitis
☐Blood in stool ☐Diverticulitis ☐Gallstones ☐Liver problems ☐Vomiting
☐Bulimia ☐Dysentery ☐Heartburn ☐Low appetite
☐Other_____

Number of bowel movements a day_____

Comments/Treatments_____

EYES/EARS/NOSE/THROAT

☐Cataracts ☐Glasses/Contacts ☐Mouth ulcers/canker sores ☐Swollen glands
☐Ear infections ☐Glaucoma ☐Oral herpes/cold sores ☐Wax build up
☐Earaches ☐Hearing aids ☐Ringing in ears/Tinnitus
☐Excessive saliva ☐Hearing loss ☐Strep throat
☐Other_____

Comments/Treatments_____

MUSCULOSKELETAL

☐Back surgery ☐Lower back pain ☐Osteopenia
☐Chronic neck/back pain ☐Metal rods/screws in body ☐Osteoporosis
☐Frequent sprains/torn ligaments ☐Neck or shoulder tightness ☐Rheumatoid arthritis
☐Osteoarthritis
☐Other_____
Comments/Treatments_____

NEUROPSYCHOLOGICAL

☐ADD/ADHD ☐Frequently feel overwhelmed ☐Poor memory
☐Anxiety ☐High stress levels ☐Suicidal thoughts (past or present)
☐Depression ☐Lose temper easily ☐Treatment through therapy
☐Difficulty concentrating ☐Obsessive compulsive disorder
☐Other_____
Comments/Treatments_____

RESPIRATORY

☐Asthma ☐Difficulty breathing ☐Laryngitis ☐Stuffy nose
☐Breathless with exertion ☐Difficult smelling ☐Pneumonia ☐Tight around lungs
☐Bronchitis ☐Emphysema ☐Respiratory inflammation ☐Tuberculosis
☐Chest pain ☐Flu ☐Runny nose ☐Wheezing
☐Common cold ☐Fluid in lungs ☐Shortness of breath
☐Coughing ☐Hay fever ☐Sneezing
☐Other_____
Comments/Treatments_____

SKIN

☐Acne ☐Dry hair ☐Hives ☐Oily hair ☐Rashes ☐Slow to heal
☐Boils ☐Dry skin ☐Impetigo ☐Oily skin ☐Scars ☐Ulcerations
☐Bruise easily ☐Eczema ☐Itching ☐Pimples ☐Sensitive to chemicals ☐Varicose veins
☐Dandruff ☐Hair loss ☐Moles ☐Psoriasis ☐Skin tags
☐Other_____
Comments/Treatments_____

URINARY TRACT

☐Bladder infections ☐Cystitis ☐Kidney infections ☐Strong smelling urine
☐Bloating ☐Frequent urge to urinate ☐Kidney pain ☐UTIs
☐Blood in urine ☐Frequent urination ☐Kidney/bladder stones ☐Water retention
☐Burning urination ☐Incontinence ☐Lower back pain ☐Wake up to urinate
☐Other_____
Comments/Treatments_____

PREGNANCY

Number of live births____ Number of miscarriages_____ Number of terminated births____
Currently using birth control? ☐Y ☐N If so, what type_____
Any issues during pregnancy?_____

PERI-MEOPAUSAL/MENOPAUSAL SYMPTOMS

☐Depression ☐Hot flashes ☐Memory problems ☐Poor concentration
☐Fatigue ☐Incontinence ☐Mood swings ☐Sore muscles
☐Headaches ☐Insomnia ☐Night sweats ☐Vaginal dryness
☐Heavy bleeding/flooding ☐Lack of libido ☐Osteoporosis ☐Weight gain
☐Other_____
Comments/Treatments_____
_____

PMS SYMPTOMS

☐Bloating ☐Food cravings ☐Insomnia ☐Pain at ovulation
☐Breast Tenderness ☐Headaches ☐Irregular cycle ☐Skipped periods
☐Cramping ☐Heavy flow/blood clots ☐Mood swings ☐Swelling
☐Other_____
Comments/Treatments_____
_____

WOMEN: REPRODUCTIVE HEALTH

☐Breast augmentation/ reduction ☐Cervical dysplasia ☐Miscarriage ☐STDs
☐Endometriosis ☐Ovarian cancer ☐Uterine cancer
☐Breast cancer ☐Fibroids ☐Ovarian cysts/PCOS ☐Vaginal dryness
☐Breast lumps/cysts ☐Infertility ☐Painful intercourse ☐Vaginal infection
☐Breast pain ☐Irregular pap ☐Pelvic inflammatory disease
☐Other_____
Comments/Treatments_____
_____

MEN: REPRODUCTIVE HEALTH

☐Benign Prostatic Hyperplasia ☐Dribbling ☐Interrupted flow of urine ☐Painful ejaculation ☐Testicle pain
☐Erectile dysfunction ☐Painful urination ☐STD
☐Blood in semen ☐Excessive sexual thoughts ☐Infertility issues ☐Penis pain ☐Vitality low
☐Blood in urine ☐Frequent urination ☐Libido low ☐Prostate cancer
☐Difficulty getting urine flowing ☐Impotence ☐Orchitis ☐Prostate pain/swelling
☐Other_____
Comments/Treatments_____
_____