LIVEDnutrition
nutrition for limitless living

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Client Intake Form

Name:_________________________________Date:___________________
Referral Source:____
Address:____
City:______________________________ST:________Zip:_______________
Phone:______-______-__________email:_________________________________
Date of Birth:_____/______/______ Sex: M F Occupation____________

Primary health concerns/goals:

1.____

2.____

3.____

4.____

5.____

Medications:____

Health History

Breastfed: Y / N If yes, how long_________________________

Sleep (circle all that apply):

Hard to fall asleep

Hard to stay asleep

Wakes up to urinate

How long has sleep been an issue____________________________________

Digestion (circle all that apply):

Bowels

Regular Irregular

Constipation Loose

Bloating Burping Gas

Bladder:

Urgency
Nighttime urination
Perineal trauma (ie: injury to pubic bone or tailbone, episiotomy, vasectomy) Y/ N

Endocrine Symptoms:

Anxiety	Difficulty falling asleep	Hair loss
Weight gain	Carb cravings	

Dental (circle all that apply):

Composite Fillings	Y N	How Many
Amalgams	Y N	How Many
Crowns	Y N	How Many
Type of Material	Porcelain	How Many
	Gold	How Many
Root Canals	Y N	How Many

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<u>Trauma Sites: deep bruises, deep cuts, surgery sites (circle all that apply):</u>

Head injuries Y N What age:

Location(s)______________

____

____

Left Foot Right Foot
Left Ankle Right Ankle
Left Knee Right knee
Left hip Right hip

Perineum Tailbone Sacrum
Lumbar spine Thoracic spine Neck Back Front

Left Hand Right Hand
Left Wrist Right Wrist
Left Arm Right Arm
Left shoulder Right shoulder
Chin Nose Forehead
Left eye Right eye
Left face Right face

Left ear Right ear

<u>RML Health and Wellness Cancellation Policy:</u>

Full appointment fee applies if cancellation occurs with less than 24 hours notice.

Acknowledgement of Cancellation Policy:________________________________