New Client Intake Form

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NOTE: this is a confidential record of your medical history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so.

Name_____ Today's Date_____
Address_____
Phone: Home/cell_____
Email_____
Date of birth_____ Age_____
Male/Female/Transgendered/gender affirming pronoun /rather not say
Height_____Weight_____
Relationship status_____ Children_____
Do you feel safe at home?_____
Occupation_____
Is there any reason why you could not take remedies made in alcohol(tinctures)?

Are you pregnant, could be pregnant, or breast/chest feeding?

Main Reason for visit (diagnoses, main complaints and symptoms) and when did it begin?

Other health issues:

Hobbies, skills, interests, favorite pastimes:

What type of daily, weekly or monthly exercise do you practice? Please be specific on how often you exercise.

Are you a current smoker? _____ How many years?____
Amount per day ? ____ Amount per month?_____Have you smoked in the past? ____
Do you use recreational drugs? _____ What? _____
Frequency? _____

Practitioners
Are you currently under the care of a healthcare practitioner? Please note which of the following types of health care practitioners you have seen.
____Ayurvedic practitioner
____Chiropractor
____Counseling
____Herbalist
____Homeopath
____Naturopath
____Social Worker
____Massage therapist
____Occupational therapist

____Physical therapist
___ Psychiatrist
___ Psychologist
____Spiritual counselor
____Traditional Chinese Medicine
__ Medical doctor
(type)_General Practitioner_____
Bodywork (type)_____Other_____

Western medical diagnosis known (please include any significant lab reports)

Other diagnosis:

Current medications and treatments including the past 6 months and over the counter medication:

Do you feel like any of these medications helped you?

Health History

Please check any of the below symptoms or diseases you have experienced. Use a 'C' for currently experiencing and a 'P' for previously experienced.

____AD(H)D
____AIDS
____Alcoholism/substance abuse
____Allergies
____Anemia
____Anxiety or panic disorder
____Arthritis
____Asthma
____Bloating
____Cancer
____Environmental sensitivities
____Epilepsy
____Epstein-Barr virus
____Excess stress
____Eyesight problems
____Fatigue
___ Fever
____Gynecological problems
____Genital Herpes
____Headaches/ migraines
____Hearing problems
____Heart disease
____Hepatitis A
____Hepatitis B
____Hepatitis C
____High blood pressure
____HIV
____Hyperglycemia
____Hypoglycemia
____Immune disorders
____Injuries
____Low blood pressure
___ Changes in appetite
____Chemical sensitivities
____Chronic fatigue
____Common cold
____Constipation
____Diabetes
____Ear Infections
____Diarrhea
____Dizziness
____Drug abuse
____Male health problems
____Memory lose
____Menopause problems
____Menstrual irregularities
___Night sweats
____Oral Herpes
____Numbness
____Painful joints
____Rashes
____Respiratory problems
___ Recent weight loss
___Recent weight gain
____Seizures
____Shingles
____Shortness of breath
____Sleep problems
____Sore throats
____Stiffness
____Stomach aches
____Swelling
____Tumors
____Urinary tract infections
Other_____

Hospitalization

Name any circumstances in which you were hospitalized and why (list approximate date and duration of stay)

Family History

Has anyone in your immediate family(parents,siblings, grandparents, children, aunt/uncle) had any of the following

___ Stroke
___ Heart Disease
___ High Blood Pressure
___ Thyroid Disease
___ Kidney Disease
___ Diabetes
___ Arthritis
___ Osteoporosis
___ Mental Health Issues
___ Migraine Headaches
___ Alcoholism
___ Asthma
___ Depression
___ Anxiety
___ Cancer/Type(s):
_____

Immune System

Please mark 'C' for current, and 'P' for previously experienced.

____Adenitis
____Allergies
____Autoimmune disorders
____Catch everything
____Chronic fatigue
____Enlarged spleen
____Graves disease
____Hashimoto's thyroiditis
____Heal slowly
____Immuno deficiency
____Infections
____Low grade fever
____Lowered resistance
____Lupus (SLE)
____Mononucleosis
____Myasthenia gravis
____Pernicious anemia
____Rheumatoid arthritis
_____Sick often
_____Sore throats
____Swollen lymph glands
_____White blood cell count
Other_____
Treatments:_____

Do you have any concerns about your immune system?

Skin

Mark any of the conditions below that pertain to you. Use 'C' for current and 'P' for previously experienced.

____Acne
____Boils
____Bruise easily
____Dry hair
____Dry skin
____Eczema/psoriasis
____Hair loss
____Impetigo
____Itchy
____Moles
____Oily hair
____Oily skin
____Pimples
____Rashes
____Scars
____Sensitive to chemicals
____Skin tags
____Slow to heal
____Varicose veins

Other_____
Treatments:_____
_____

Head, Eyes, Ears, Nose and Throat

____ Poor vision
____ Cataracts
____ Glaucoma
___ Earaches
____ Blurred vision
____ Poor hearing
____ Ringing in ears
____ Sore throat
____ Canker sores
____ Cold sores
____ Grinding teeth
____ Nosebleeds
____ Facial pain
____ Clicking jaw
____ Eye pain
____ Sinus congestion
____ Mucous in throat
____ Dizziness
____ Frequent colds
____ Spots in front of eyes
____ Swollen glands

Any other problems with the head?
_____
_____
Treatments:_____
_____

Respiratory

Please mark with a 'C' for currently experience and 'P' for previously experienced.

____Asthma
____Bronchitis
____Chest pain
____Common cold
____Coughing
____Difficulty smelling

____Flu (influenza)
____Fluid in lungs
____Hay fever
____Laryngitis
____Pleuritis
___Respiratory inflammation
____Runny nose
____Shortness of breath
____Sneezing
____Stuffy nose
____Tight around lungs
____Trouble breathing in
____Trouble breathing out
____ Wheezing
____Tuberculosis
Other_____
Treatments:_____
_____
_

Do you have much congestion, which season is it worse and best? What helps it?

Mucous- quality and/or color

____Clear ____Green ____Yellow
____Thick/sticky ____Thin/runny
Worse in the morning, afternoon, evening, night (circle) Have you identified foods, environmental factors or situations that worsen your breathing. What are they?

Cardiovascular Health

Please check the below questions pertinent to your health

____Angina
____Arrythmias(irregular heartbeat)
____Arteriosclerosis
____Black and blue easily
____Bleed easily
____Capillary fragility
____Cardiac arrest
____Chest pains
____Congenital deformities
_____
____Congestive heart failure
____Edema
____Fast heart beat (tachycardia)
____Heart attack(myocardial infarction)
____Heart flutter
____Heart irregularities
____Heart murmur
____High blood pressure
____Ischemia
____Low blood pressure
____Mitral valve prolapse
____Palpitation
____Pericarditis
____Poor circulation
____Rheumatic fever
____Slow heart beat (bradycardia)
____Stroke
____Varicose veins
Other_____
Treatments:_____
_____

Resting pulse rate_____ Blood pressure (avg)_____ Cholesterol (if know, LDL, HDL and total cholesterol)
Treatments:_____

Nervous System and Stress

Please mark 'C' for current and 'P" for previously experienced.

____Anxiousness
____Bipolar
____Butterflies in stomach
____Cannot stay asleep
____Constant feeling of stress
____Diminished taste
____Depression
____Fear of facing a new day
____Fluctuating vision
____Hard to concentrate
____Involuntary spasms
____Mania
____Memory loss
____Nervousness
____Numbness
_____Obsessive thoughts
____Pain – constant
____Panic attacks
____Seasonal affective disorder
____Sudden mood swings
_____Suicidal thoughts
____Trouble falling asleep
____Twitching
____Worsening coordination
Other_____
Treatments:_____
_____
_____

Describe your stress levels, what goes wrong with your body when stress levels are elevated?

How do you cope with your stress?

Sleep Patterns

On a scale from 1 (rarely) to 5 (very often) mark the conditions pertinent to you.

____Fall asleep fast
____Sleep through the night
____Hard to fall asleep, but stay asleep
____Hard to fall and stay asleep
____Wake often
____Wake up to urinate
____Restless sleep
____Restful sleep
____Hard to wake up
____Stay awake till 11:00pm
____Stay awake till 1:00am
____Stay awake till 3:00am
Other_____
Treatment:_____
_____
_____

Generally, how many hours of sleep do you need to feel rested?
Do you feel rested when you wake in the morning?

Energy Levels:
Are you satisfied with your energy levels, please describe

When is the high point and low point of your daily energy levels?

Have your energy levels changed markedly at any point recently or in your past. What preceded this change?

Diet
Do you follow a special diet? Yes No
If YES, please check appropriately:
___Vegetarian ___Vegan ___Low Fat
___Low Carb ___High Fiber ___Calorie Restriction
Other: _____
Have you ever binged, purged, or restricted your food intake?
No Yes, I have _____ (please describe)

What did you have for breakfast, lunch and dinner yesterday?

Breakfast_____

Lunch_____

Dinner_____

What concerns, if any, do you have about your eating practices?

_____

Digestion:

Please use 'C' for Current, and 'P' for previously experienced.

____Anorexia nervosa
____Belching
____Bulimia
____Changes in bowel habits
____Crohn's disease
____Constipation
____Diarrhea
____Diverticulitis
____Dysentery
____Eating disorders
____Flatulence
____Food unappetizing
____Gallstones
____Giardia
____Heartburn
____Reflux
____Hemorrhoids
____Indigestion
____Irritable bowel syndrome
____Large appetite
____Liver problems
____Low appetite
____Nausea
____Pain after eating
____Parasites
____Shigella
____Stomach aches
____Sudden weight change
____Ulcer
____Ulcerative colitis
____Vomiting
Other_____
Treatments:_____
_____
____ # of bowel movements per day
____ Loose ____ Normal ____ Hard?
Stools: ____ float____ blood in stool
Do you rely on any of the following for bowel elimination? Yes ___ No ___ How often? ___
____ Enemas
____ Laxatives ____ Purgatives ____ What type/brand? _____

AMAB (Assigned Male at Birth)

Have You had any of the following symptoms: Mark "C" for current, "P" for previously experienced.

____Benign Prostatic Hyperplasia (BPH)
____Blood in semen

____Blood in urine
____Difficulty getting urine flowing
____Dribbling
____Erectile dysfunction
____Excessive sexual thoughts
____Frequent urination
____Impotence
____Interrupted flow of urine
____Libido low
____Orchitis
____Painful ejaculation
____Painful to urinate
____Penis pain
____Prostate pain
____Testicle pain
____Vitality low
Other_____
Treatments:_____
_____

Does your prostate region ever hurt? If yes, is pain dull, constant, throbbing or sharp?

Is it ever painful to urinate – describe the pain
If you are over 50 years of age Do you have annual PSA screening?

Last screening:

Do you have any health concerns about your sexuality or vitality?

Hows your sex life?

What type of birth control do you use?

Reproductive – Female Bodied (AFAB)
Use 'C' for current condition, 'P' for previous.
____Breast pain
____Cervical dysplasia
____Cysts
____Endometriosis
____Infertility
____Miscarriage
____Painful intercourse
_____Pelvic Prolapse
____Pelvic inflammatory disease (PID)
____STDs
____Tumors
____Fibroids
____Unusual PAP
____Vaginal discharge
____Vaginal dryness
____Vaginal infection
_____Vaginitis
____Breast cancer
____Intersistial cystitis
Other_____

Date of last PAP/ results:
Date of last mammogram:

Menstrual Cycle

____Acne
____Bleeding between cycles
____Mood swings
____Bloating (hands, stomach)
____Bloating (feet, hands, ankles)
____Irregular cycle
____Heavy Flow
____Painful menses
____Food Cravings
____Breast Tenderness
____Insomnia
___Depression
___Anxiety
Other_____
Treatment:_____
_____

Average number of days you bleed?
Approximately how many days between menses, is it regular or irregular?

Menopause:

Are you currently in pre, peri or postmenopausal? Y N

____Dry vaginal mucosa
____Hormone replacement therapy
____Hot flashes
____Mood swings
____Night sweats
____Osteoporosis
____Sore muscles
Other_____
Treatment:_____
_____

Birth Control:

Are you currently using birth control? Y N
If YES: Which type are you using?

____Birth control pills
____IUD
____Diaphragm
_____Foam
_____Pull out
_____Condoms
_____Natural Tracking
Other_____

Pregnancy:

Have you ever been pregnant?
Number of live births:
Number of miscarriages:
Number of terminations:
Are you or could you be pregnant now?
Infertility issues:

Hormones for Gender affirming Transitioning

If not applicable, please check here ___ and skip to the next section.

Are you currently taking hormones for gender affirming purposes? Yes No If YES:

How long have you been taking them? _____

What hormones are you taking? _____

Do you feel supported with your decisions? Yes No

Are you working with a licensed Health Practitioner? Yes No

Have you ever used transitioning hormones in the past? Yes No

If YES to past or current hormone use, what types of complications, if any, have you experienced?

_____

_____

_____

_____

What types, if any, of gender affirming surgery have you had?

_____

_____

_____

_____

_____

_____

What types of complications, if any, have you experienced following such surgeries and/or procedures? _____

_____

_____

_____

What concerns or questions, if any, do you have regarding gender affirming transitions or surgeries?

_____

_____

_____

_____

Are their any other concerns you wish to share? If there was a magic wand and I could help you with one thing what would that be? Please use the back of this page to write anything else you feel may be important.

Informed Consent:

I _____, hereby attest and agree to the following:

I fully understand that Alex weinert is a lay natural health ADVISOR and TEACHER who deals strictly in helping people to improve their general health and fitness through better nutrition,improved lifestyle, health habits, and positive mental attitudes.

I fully understand that alex weinert is NOT a licensed physician, and cannot diagnose diseases, prescribe drugs, or recommend treatments for specific disease conditions.

I understand that said evaluations cannot determine specific disease conditions I may have, and do not replace the diagnostic services offered by licensed physicians.
I understand that alex weinert neither claims, nor implies, that any instruction, advice, counsel, suggestions, recommendations, services, or products, provide, whether in person or by mail or by telephone, will cure, treat, prevent, or mitigate any disease condition; but are
provided solely for the purpose of increasing energy, supporting the natural function of body systems, and otherwise improving general health and fitness.

I have read and understand the foregoing and agree to the terms and conditions set therein.
I have received a copy of this agreement.
Dated this _____ Day of _____, 20___

_____
Client Signature