Intake Form

Basic Info:

Client Name:_____ _____
Email:_____
Home phone: _____Cell phone: _____
Address:_____
City: _____State:_____Zip: _____
Emergency contact: _____ Number: _____
Gender _____Age _____ DOB _____ Ht. _____ Wt. _____
Occupation: _____Hours work per week:_____
How long there? _____Do you like your job? _____
Were you referred by anyone: Y/N Who: _____
Stress level (1-10) _____ Blood type _____ Blood pressure _____
List your stressors_____
_____
When is your usual bedtime? _____Rising time? _____Sleep quality?_____

List regular physical activities and duration: _____
_____

Have you ever worked with a nutritionist, energy healer or an intuitive?
◊ Yes ◊ No _____

What are your hobbies?_____

Do you have any physical injuries? ◊ Yes ◊ No
If so, please list:_____

Have you ever been diagnosed with any ailments or diseases? If so, please explain: _____
_____

Do you have any recurring physical pain? ◊ Yes ◊ No

Do you feel like you have a good support system of family and friends?
◊ Yes ◊ No
If yes, list two supportive friends/family and their level of support (scale 1-10, 10 being ultimate support)

_____
_____

Emotional Questionnaire:

How would you describe your overall well-being? (Physical, Mental, Emotional, Energetic)_

_____

_____

Are you willing to make changes in your life to support becoming the best version of yourself?

◊ Yes ◊ No

Do you believe in a spiritual higher power? ◊ Yes ◊ No

Do you meditate? ◊ Yes ◊ No

Do you live in abundance or in lack?_____

Have you ever been abused in any way? (Physically, Sexually, Emotionally or Mentally)

◊ Yes ◊ No

On a scale of 1 to 10 (10 being highest)

How fulfilled do you feel in life?_____

How are your anxiety levels? _____

Your needs are met emotionally? _____

If not, why do you feel this way? _____

_____

Do you love and accept yourself as you are? (10 being fully accepting and in

love with yourself)_____

Do you have any history of depression? ◊ Yes ◊ No

Did you have a good loving relationship with your parents growing up?

Mother? ◊ Yes ◊ No

Father? ◊ Yes ◊ No

Are you married, single, in a significant relationship or other?_____

Are you fulfilled in your current relationship status? ◊ Yes ◊ No

If not, briefly describe what would have to change in order to be more fulfilled in this area of

your life?_____

_____

Is it easy for you to speak honestly about what is on your mind? ◊ Yes ◊ No

If no, what do you think holds you back?_____

_____

_____

If there were something you could change in your life what would it be? _____

_____

_____

Do you notice any habitual patterns you have? ◊ Yes ◊ No

If so, please explain:_____

_____

_____

What are some of your personal goals or intentions? _____

_____

_____

Is there anything else you would like me to know about yourself?_____

_____

_____

_____

General Medical:

How would you describe your health in general?

_____

How often do you have a bowel movement? _____

Do you:

Use recreational drugs? _____ What kind and how often? _____

Dental work done_____

Do you have amalgam (silver) fillings? _____ How many?_____

When was the last time you were on a course of antibiotics?

_____

What were they prescribed for?

_____

Primary Care Physician: _____ Number: _____
Are you currently being treated for any medical conditions? ◊ Yes ◊ No Please explain:_____
Do you have any known food allergies? ◊ Yes ◊ No

What are they and how do they affect you?

_____

Do you have seasonal allergies? _____ Are you currently on a diet? ◊ Yes ◊ No

Please explain:

_____

Do you weigh yourself? ◊ Yes ◊ No How often? _____
Highest weight: _____Age _____Lowest weight: _____ Age _____

What would you like to weigh?_____

Nutrition and Eating habits:

On average, how many times a week do you: Cook full meals at home? _____
Do you enjoy cooking? _____

Do you like leftovers?_____ Eat alone? _____ Shop for food? _____
Do you enjoy grocery shopping? _____

Where do you usually shop for food?
_____
Eat and work simultaneously? _____ Microwave your food? _____

Eat at a restaurant? _____ How often do you dine out? _____

What restaurants do you like?
_____

Eat breakfast? _____ Eat in the car? _____ Eat meat? _____ Skip meals? _____

What popular diets have you tried and what were your experiences with them?
_____
_____
Do you drink coffee? _____ How much per day? _____

Do you drink sodas? _____ How many per day? _____
How much water do you drink per day? _____

List your favorite foods
_____

List foods that you absolutely will not eat
_____

What foods are you not willing to give up?
_____

Religious or Dietary Restrictions?
_____

What are impediments to a change in your diet/nutrition/habits?
_____
_____