

# Client Intake Form



Client Name \_\_\_\_\_ Date \_\_\_\_\_

## Client Information

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_ What form of communication do you prefer?  Phone Call  Skype

E-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status:  Single  Married  Partnership  Divorced  Separated  Widowed

Spouse/Partner Name \_\_\_\_\_ # of Children \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Contact Phone:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

## Primary Health Care Provider

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**I give my therapist permission to consult with my health care provider regarding my health and treatment.**

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

## 1. Current Health Information

Height \_\_\_\_\_ Weight \_\_\_\_\_ Natural hair color: \_\_\_\_\_ Do you use hair dye? \_\_\_\_\_

Ethnic Identity \_\_\_\_\_ Special shampoo \_\_\_\_\_

### List Health Concerns

#### Primary

Mild  Moderate  Disabling  Constant  Intermittent

- Symptoms ↑ w/activity
- Symptoms ↓ w/activity
- Getting worse  Getting better  No change

**Treatment Received**

\_\_\_\_\_

**Secondary**

\_\_\_\_\_

- Mild  Moderate  Disabling  Constant  Intermittent
- Symptoms ↑ w/activity
- Symptoms ↓ w/activity
- Getting worse  Getting better  No change

**Treatment Received**

\_\_\_\_\_

**Have you ever received Energy Therapy before?**

Yes  No Frequency? \_\_\_\_\_

**Have you ever received Manual Therapy before?**

Yes  No Frequency? \_\_\_\_\_

**Have you ever received Psychotherapy before?**

Yes  No Frequency? \_\_\_\_\_

**What kinds of practitioners (formal/informal) have you worked with around food/diet/nutrition** (example: Dietician, Health Coach, or Nutritional Therapist)?

\_\_\_\_\_

**List all conditions currently monitored by a Health Care Provider.**

\_\_\_\_\_

**List Daily Activities**

Work \_\_\_\_\_

Work Hours and Schedule \_\_\_\_\_

Do you now or have you ever worked the night shift?  Yes  No

If so, please explain \_\_\_\_\_

If currently, what are your hours? \_\_\_\_\_

Home/Family \_\_\_\_\_

Social/Recreational \_\_\_\_\_

Circle the above activities affected by your condition.

All of the above

Check other activities affected:

Sleep  Washing  Dressing  Fitness

How do you reduce stress? \_\_\_\_\_

Pain? \_\_\_\_\_

What are your goals for receiving therapy? \_\_\_\_\_

## 2. Health History

List & include dates & treatments. Add pages if necessary.

Surgeries \_\_\_\_\_

\_\_\_\_\_

Accidents (physical -psychological) \_\_\_\_\_

\_\_\_\_\_

Major Illnesses \_\_\_\_\_

\_\_\_\_\_

### Women

Last Pap \_\_\_\_\_ First day of last menstrual period \_\_\_\_\_

Marital/Partner History (Years Married) \_\_\_\_\_ Number of Children \_\_\_\_\_

Ages of Children \_\_\_\_\_ Number of pregnancies \_\_\_\_\_

Complications \_\_\_\_\_

Use of Contraceptive  Yes  No

What type? \_\_\_\_\_

Abortions/Miscarriages? \_\_\_\_\_

### 3. Lifestyle Factors

#### Exercise Activities

Please fill in the approximate amount for each type of exercise that you do. Include the amount of time spent (hours/minutes) and the frequency.

Type	Hours	Minutes	Never	0-1 times/week	1-2 times/week	3-5 times/week	Daily
E.g., Swim							
Bike							
Dance							
Garden							
Golf							
Hike							
Pilates							
Run							
Swim							
Tennis							
Ski							
Walk							
Weights							
Yoga							
Other: _____							
Other: _____							

#### 4. Family Medical History

Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death.

Mother:

Father:

Siblings:

Mother's parents:

Father's parents:

#### 5. Current Dietary Habits

Please list any specific diets that you are currently following, for example, vegan diet (no dairy, meat, fish or eggs), vegetarian, Atkins, paleo, DASH, raw, GAPS, etc:

**Eating Behaviors** / Briefly describe your mealtime and snack patterns:

#### Food Allergies and Sensitivities

- Wheat allergy     Wheat sensitivity
- Dairy allergy     Dairy sensitivity

Please list any other known or suspected food allergies and sensitivities: \_\_\_\_\_

Are there foods you could not give up? If so, which ones? \_\_\_\_\_

## Current Food Preparation Methods

Who's doing the shopping?  You  Family member  Friend  Other

Do you eat with people or alone?  People  Alone

Do you eat out?  Yes  No

If so, how often?  Once  Monthly  Twice monthly  Weekly/Daily

What kinds of places do you eat out? \_\_\_\_\_

Do you prepare your own food?  Yes  No

Do you enjoy cooking?  Yes  No

How do you feel about food preparation and cooking? \_\_\_\_\_

How much time do you spend preparing food each day?  Never  1 hour  2 hours  3 hours

## Food Symptoms

Please circle any of the following food symptoms that you experience on a regular basis:

- |                                       |                                     |                                   |
|---------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Burping    | <input type="checkbox"/> Itching  |
| <input type="checkbox"/> Sinus        | <input type="checkbox"/> Flatulence | <input type="checkbox"/> Flushing |
| <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Bloating   |                                   |

## 6. Diet History

Were you breastfed, and if so, until what age?  Yes  No Until age: \_\_\_\_\_

Were you fed formula as a baby?  Yes  No

Did you experience ear infections as a child?  Yes  No

Use of antibiotics as a child/adult?  Yes  No

Please list any other childhood illnesses and the age at which they occurred: \_\_\_\_\_

Please list any digestive complaints you recall having as a child (for example, stomach pains, diarrhea, constipation, gas, etc.) \_\_\_\_\_

Please list any other physical complaints you recall as a child (for example, fatigue, headaches, pain): \_\_\_\_\_

Acne as an adolescent?  None  Mild  Moderate  Severe

History of fasting?  Yes  No

Did you experience any eating disorders during adolescence?  Yes  No



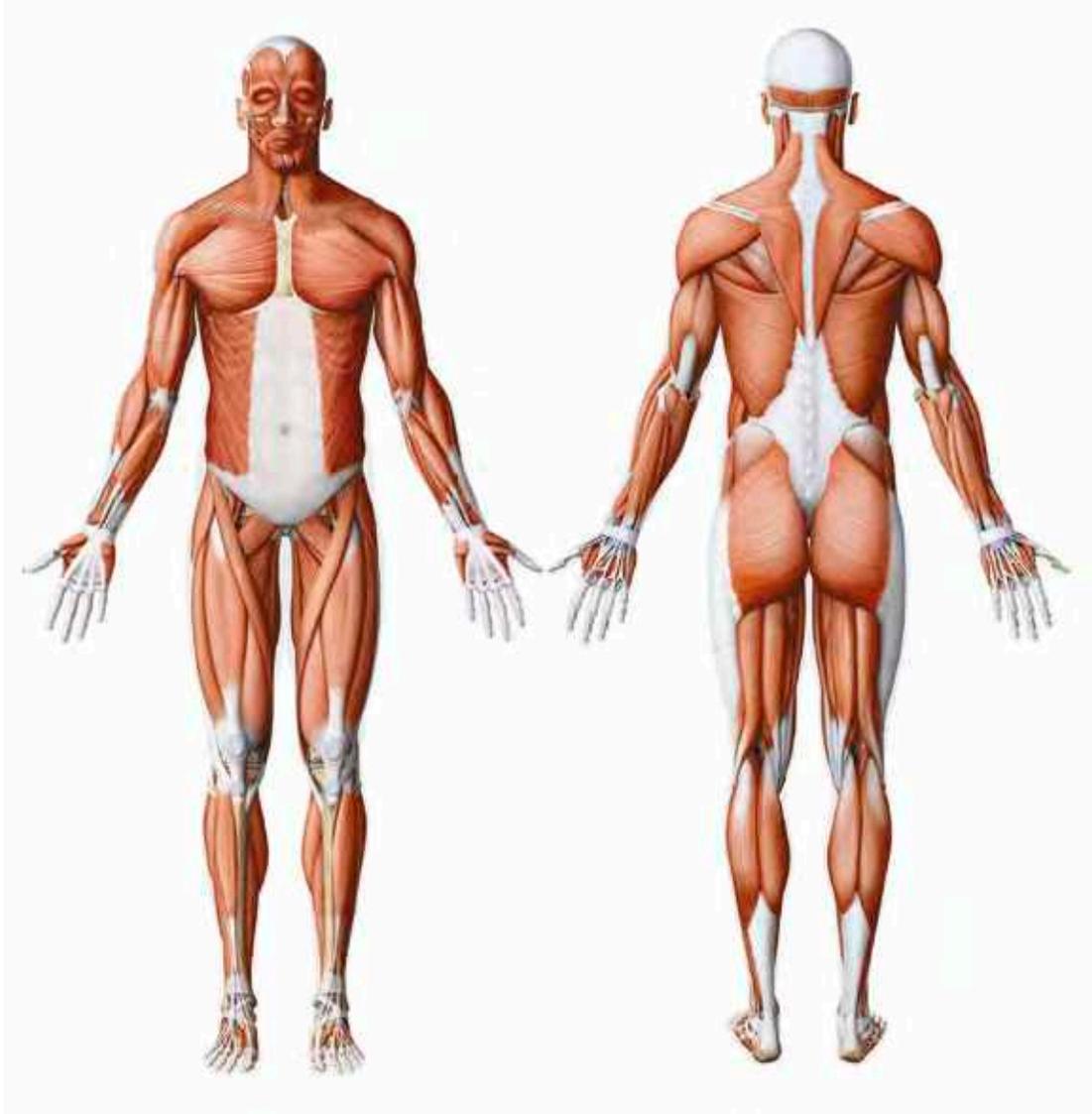


## 10. Detoxification

If you are currently or have previously done any detoxification methods, please indicate which ones by filling in the table below. If you have done a detoxification method that is not listed in the table, write the name of it in the row marked “other.”

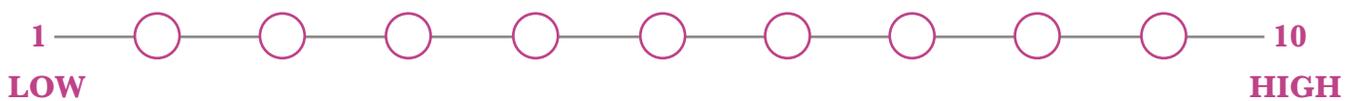
Method	How Often	When	Dates/Duration	Desired/Perceived Benefits
E.g., Skin Brushing	1–2 times / day	Before bathing	2013–present	Strengthen immunity
Skin Brushing				
Coffee Enema				
Liver Flush				
Juice Fast				
Colon Cleanser				
Epsom Salt Bath Soak (magnesium sulfate)				
Salt and Baking Soda Bath				
Vinegar Bath				
Sweats/ Saunas				
Castor Oil Packs				
Master Cleanse				
Other:				

## 11. Pain / Discomfort



Please describe the location and experience of pain:

Rate your stress level as of today



## 12. Check all Current and Previous Conditions (please explain)

### General

CURRENT PAST

#### Comments

- |                          |                          |                        |  |
|--------------------------|--------------------------|------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | headaches              |  |
| <input type="checkbox"/> | <input type="checkbox"/> | pain                   |  |
| <input type="checkbox"/> | <input type="checkbox"/> | sleep disturbances     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | fatigue                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | infections in the ears |  |
| <input type="checkbox"/> | <input type="checkbox"/> | fever                  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | sinus                  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | other                  |  |
- 

### Nervous System

C P Comments

- |                          |                          |                                |  |
|--------------------------|--------------------------|--------------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | head injuries, concussions     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | dizziness, ringing in the ears |  |
| <input type="checkbox"/> | <input type="checkbox"/> | loss of memory, confusion      |  |
| <input type="checkbox"/> | <input type="checkbox"/> | numbness, tingling             |  |
| <input type="checkbox"/> | <input type="checkbox"/> | sciatica, shooting pain        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic pain                   |  |
| <input type="checkbox"/> | <input type="checkbox"/> | depression                     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | other                          |  |
- 

### Skin Conditions

C P Comments

- |                          |                          |                       |  |
|--------------------------|--------------------------|-----------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | rashes                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | athlete's foot, warts |  |
| <input type="checkbox"/> | <input type="checkbox"/> | other                 |  |
- 

### Respiratory, Cardiovascular

C P Comments

- |                          |                          |                                 |  |
|--------------------------|--------------------------|---------------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | heart disease                   |  |
| <input type="checkbox"/> | <input type="checkbox"/> | blood clots                     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | stroke                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | lymphadema                      |  |
| <input type="checkbox"/> | <input type="checkbox"/> | high, low blood pressure        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | irregular heart beat            |  |
| <input type="checkbox"/> | <input type="checkbox"/> | poor circulation                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | swollen ankles                  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | varicose veins                  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | pregnancy                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | chest pain, shortness of breath |  |
| <input type="checkbox"/> | <input type="checkbox"/> | asthma                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | palpable heartbeat in abdomen   |  |
| <input type="checkbox"/> | <input type="checkbox"/> | other                           |  |
- 

### Allergies

C P Comments

- |                          |                          |                       |  |
|--------------------------|--------------------------|-----------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | scents, oils, lotions |  |
| <input type="checkbox"/> | <input type="checkbox"/> | detergents            |  |
| <input type="checkbox"/> | <input type="checkbox"/> | other                 |  |
- 

### Muscles and Joints

C P Comments

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | rheumatoid arthritis     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | osteoarthritis           |  |
| <input type="checkbox"/> | <input type="checkbox"/> | scoliosis                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | broken bones             |  |
| <input type="checkbox"/> | <input type="checkbox"/> | spinal problems          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | disk problems            |  |
| <input type="checkbox"/> | <input type="checkbox"/> | lupus                    |  |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ, jaw pain            |  |
| <input type="checkbox"/> | <input type="checkbox"/> | spasms, cramps           |  |
| <input type="checkbox"/> | <input type="checkbox"/> | sprains, strains         |  |
| <input type="checkbox"/> | <input type="checkbox"/> | tendonitis, bursitis     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | stiff or painful joints  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | weak or sore muscles     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | neck, shoulder, arm pain |  |
| <input type="checkbox"/> | <input type="checkbox"/> | low back, hip, leg pain  |  |

### Digestive/Elimination System

C P Comments

- |                          |                          |  |  |
|--------------------------|--------------------------|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | bowel dysfunction  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | gas, bloating/bladder/kidney dysfunction<br>abdominal pain |  |
| <input type="checkbox"/> | <input type="checkbox"/> | ulcers, colitis  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | belching/gas within 1 hour after eating                    |  |
| <input type="checkbox"/> | <input type="checkbox"/> | heartburn/acid reflux                                      |  |
| <input type="checkbox"/> | <input type="checkbox"/> | bloating within 1 hour after eating                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | bad breath (halitosis)                                     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | sweat has strong odor                                      |  |

### Digestive/Elimination System (Cont).

C	P	Comments
<input type="checkbox"/>	<input type="checkbox"/>	feel like skipping breakfast
<input type="checkbox"/>	<input type="checkbox"/>	feel better if you don't eat
<input type="checkbox"/>	<input type="checkbox"/>	sleepy after meals
<input type="checkbox"/>	<input type="checkbox"/>	stomach pains/cramps
<input type="checkbox"/>	<input type="checkbox"/>	diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	undigested food in stool
<input type="checkbox"/>	<input type="checkbox"/>	pain between shoulder blades
<input type="checkbox"/>	<input type="checkbox"/>	stomach upset by greasy foods
<input type="checkbox"/>	<input type="checkbox"/>	nausea
<input type="checkbox"/>	<input type="checkbox"/>	light or clay colored stools gallbladder attacks
<input type="checkbox"/>	<input type="checkbox"/>	diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	undigested food in stool
<input type="checkbox"/>	<input type="checkbox"/>	pain between shoulder blades
<input type="checkbox"/>	<input type="checkbox"/>	stomach upset by greasy foods
<input type="checkbox"/>	<input type="checkbox"/>	nausea
<input type="checkbox"/>	<input type="checkbox"/>	light or clay colored stools
<input type="checkbox"/>	<input type="checkbox"/>	gallbladder attacks
<input type="checkbox"/>	<input type="checkbox"/>	gallbladder removed
<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids or varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	chronic fatigue / fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	pulse speeds after eating
<input type="checkbox"/>	<input type="checkbox"/>	airborne allergies, hives
<input type="checkbox"/>	<input type="checkbox"/>	sinus congestion, "stuffy head"
<input type="checkbox"/>	<input type="checkbox"/>	crave bread or noodles
<input type="checkbox"/>	<input type="checkbox"/>	alternating constipation/diarrhea crohn's disease
<input type="checkbox"/>	<input type="checkbox"/>	asthma
<input type="checkbox"/>	<input type="checkbox"/>	sinus infections
<input type="checkbox"/>	<input type="checkbox"/>	use over-the-counter pain medications
<input type="checkbox"/>	<input type="checkbox"/>	anus itches
<input type="checkbox"/>	<input type="checkbox"/>	history of antibiotic use
<input type="checkbox"/>	<input type="checkbox"/>	fungus or yeast infections
<input type="checkbox"/>	<input type="checkbox"/>	irritable bowel/colitis
<input type="checkbox"/>	<input type="checkbox"/>	other

### Endocrine System

C	P	Comments
<input type="checkbox"/>	<input type="checkbox"/>	thyroid dysfunction
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	diabetes
<input type="checkbox"/>	<input type="checkbox"/>	other

### Reproductive System

C	P	Comments
<input type="checkbox"/>	<input type="checkbox"/>	pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	reproductive problems
<input type="checkbox"/>	<input type="checkbox"/>	painful, emotional menses
<input type="checkbox"/>	<input type="checkbox"/>	fibrotic cysts
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors
<input type="checkbox"/>	<input type="checkbox"/>	benign malignant

### 13. Meaning of Food

Please describe in a few sentences what food means to you. There may be both positive and negative associations. There is no right or wrong to this answer. For example, is food important to you? Are you preoccupied with it? Does it feel nourishing? Does food cause fear or discomfort?

### 14. Motivation for Nutritional Change

Identify 3 reasons to improve your diet:

Identify 3 obstacles to improving your diet:

Identify 3 goals to improve your diet:

3 month goal

6 month goal

12 month goal

Identify 3 goals to improving your food preparation:

3 month goal

6 month goal

12 month goal