Client Forms Intake Survey * Required				
1.	Name: *			
2.	Address:			
3.	City:			
4.	State:	-		
5.	Zip:			
6.	Email:			
7.	Cell Phone:			

- 8. Home Phone:
- 9. Birth Date:

Example: January 7, 2019

## 10. Reason For Consultation:

11. Health Care Professionals Consulted in the Past Year:

Skip to question 12

Lifestyle

Lifestyle Questions

12. Occupation

- 13. Hours per week spent:
- 14. Time spent sitting at work:

Mark only one oval.

1-2

\_\_\_\_\_2-4

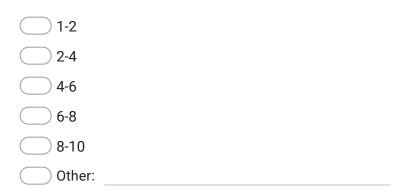
\_\_\_\_\_ 4-6

6-8

8-10

Other:

15. Time spent sitting during free time on average:



16. Time Spent for Physical Activity:

Mark only one oval.

1/2 Hour	
3/4 Hour	
1 Hour	
1 1/2 Hours	
2 Hours	
Other:	

17. Please describe current exercise routines:

18. Sleep Duration

Mark only one oval.

2-4
4-6
6-8
8-10
Other:

19. How often do you wake up throughout the night?

Mark only one oval.

Never

Infrequently

Often

- Consistently
- 20. # Of times to wake through out the night?
- 21. How often do you feel stressed?

Mark only one oval.

Rarely Stressed

Sometimes Stressed

- Oftentimes Stressed
- Very Stressed
- Excessively Stressed
- 22. Do you have destressing activities you enjoy? If so please write them down or if personal take note.

23. What are the causes of your stress?

https://docs.google.com/forms/d/18tY3mL9S10vcnUZVYI-GM6X49hSdNoTIKI295upYjX8/edit

### 24. How well do you manage your stress



25. Are you medicated in anyway or self medicated? Please include herbal supplements, drugs of any form, past medications, and frequency of use. (As a friendly reminder all information is kept confidential and we really place no judgment, simply the more we know the better we can help!)

26. How often do you prepare your own food?

(	)	Never
	/	

- Rarely (Once or Twice every two weeks)
- Infrequently (Once or Twice a week)
- Occasionally(4-5 times a week)
- Frequently(6-14 times a week)
- Consistently(15-21 or more a week)
- Other:
- 27. List the common ways you prepare your foods.(Ex: Baking, sauté, steam, boil, fry, airfry, etc.) Feel free to add types of food cooked.

28. How salty do you like your food?

Mark only one oval.

Little to no Salt

A few Dashes

Multiple Dashes (think movie theater popcorn)

Lots of salt

- Other:
- 29. Food Preparation. Guess roughly how you would split your consumption into High fat and Low fat contents as a percent or whole number.

Mark only one oval.

High Fat%

Low Fat%

30. Food Preparation. Guess roughly how you would split your consumption of grains into Refined Grains and Whole Grains as a percent or whole number.

Mark only one oval.

Refined Grain%

Whole Grain%

31. How often do you eat convenience foods?

Mark only one oval.

Never/Rarely	
1-3 times per month	
1-3 times per week	
Daily	
Other:	

32. Do you eat at least two meals at a regular time daily?

Mark only one oval.

Never		
Occasionally		
Sometimes		
Often		
Always		
Other:		

33. How often do you eat snacks

- O Never
- Occasionally
- Sometimes
- Often
- Always

34. How often do you consume alcoholic beverages? Please describe in standard drinks and frequency (S

## What is a Standard Drink?

A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are standard drink equivalents as well as the number of standard drinks in different container sizes for each beverage. These are approximate, as different brands and types of beverages vary in their actual alcohol content.

STANDARD DRINK EQUIVALENTS BEER or COOLER	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
12 oz. <b>5% alcohol</b> MALT LIQUOR 8-9 oz. <b>7</b> M eleskel	<ul> <li>12 oz. = 1</li> <li>16 oz. = 1.3</li> <li>22 oz. = 2</li> <li>40 oz. = 3.3</li> <li>12 oz. = 1.5</li> <li>16 oz. = 2</li> <li>22 oz. = 2.5</li> <li>40 oz. = 4.5</li> </ul>
~7% alcohol TABLE WINE	
5 oz. 6 6 7 2% alcohol	• a 750 mL (25 oz.) bottle = 5
80-proof DISTILLED SPIRIT 1.5 oz. 40% alcohol	<ul> <li>s a mixed drink = 1 or more*</li> <li>a pint (16 oz.) = 11</li> <li>a fifth (25 oz.) = 17</li> <li>1.75 L (59 oz.) = 39</li> <li>*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.</li> </ul>

35. How would you describe your caffeine intake on a weekly basis?

36. Do you have any medical limitations? Please give a description and treats you have undergone or are undergoing.

37. Are there any religious, spiritual, or personal beliefs that we should be aware of that could affect our choice of treatment with you?

#### General Health Questionnaire

Read each question. If it does not apply to you, leave it blank. If it does apply, rate it on a degree of severity (1= extremely mild, 10=very severe or unbearable) in the brackets before the question, and write

any explanations needed after the question.

## 38. Degree your are overweight

Mark only one oval.

## 39. Degree you are underweight



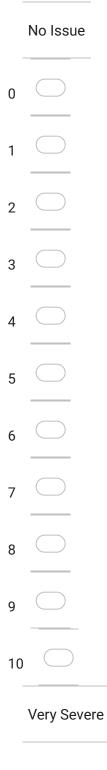
## 40. Heart problems



## 41. Experience rapid heartbeats



## 42. Aware of skipping beats



## 43. Blood pressure problems



## 44. Circulatory problems



## 45. Episodes of dizziness?



## 46. Cold hands or feet?



#### 47. Varicose veins?



#### 48. Seems to have excessive thrist?



## 49. Usually tired most of the time?



## 50. Usually jumpy or nervous?



## 51. Suffer from epilepsy or seizures?

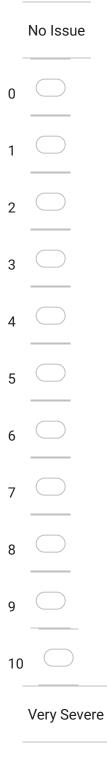


## 52. Suffer from motion sickness?



53.

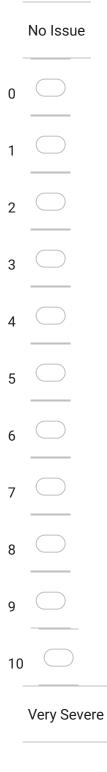
# Eye condition?



## 54. Sensitive to bug bites?

Mark only one oval.

## 55. Loss of memory?



## 56. Confusion?

Mark only one oval.

No Issue

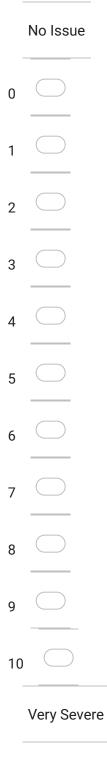
## 57. Get lightheaded when you stand quickly?



## 58. Bright lights bothersome to eyes?



## 59. Trouble falling asleep?



## 60. Wake at night at regular times?



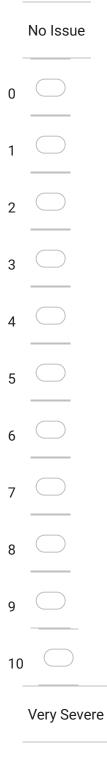
#### 61. Sweat for no reason at night?



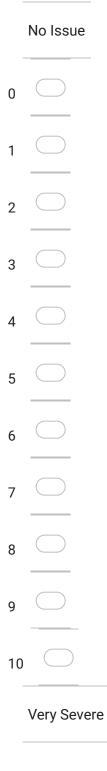
#### 62. Wake up tired after a good nights sleep?



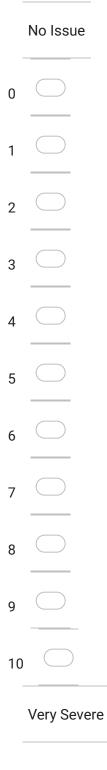
# 63. Frequently feel hot?



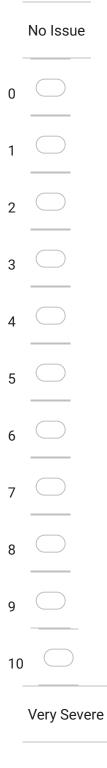
# 64. Frequently feel cold?



# 65. Eating relieves fatigue?



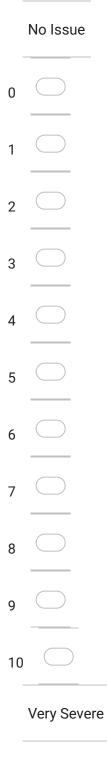
# 66. Feel shaky when hungry?



#### 67. Poor concentration?



# 68. Sexual problems?



69. What is your sex?

Mark only one oval.

Male Skip to question 70

Female Skip to question 72

Prefer not to say Skip to question 88

Skip to question 88

#### Male General Health

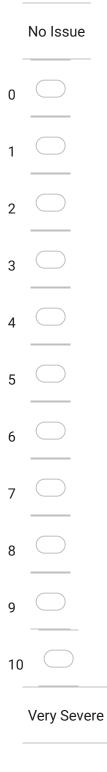
Only apply for your sex.

# 70. Prostate, dribbling after urination, difficulty starting stream?



#### 71. Impotency or decrease sexual desire?

Mark only one oval.



Skip to question 88

# Female General Health

Only apply for your sex.

# 72. Are you pregnant?

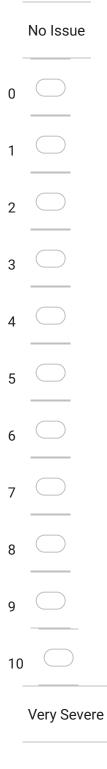
Check all that apply.

Yes		
No		
Maybe		
Other:		

# 73. Morning sickness?



#### 74. Take birth control pills?



# 75. Suffer from PMS?



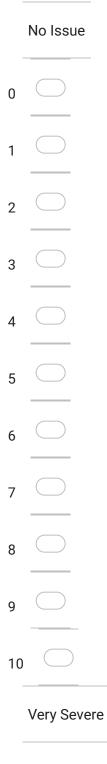
# 76. Retain fluid during period?



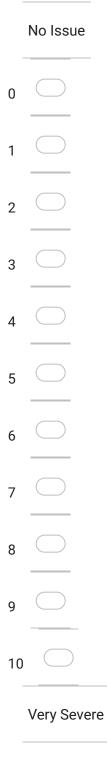
# 77. Dysmenorrhea (menstrual cramps/pain)?



# 78. Suffer from frequent yeast infections?



#### 79. Intercourse is painful?



#### 80. Diminished sex drive?

Mark only one oval.

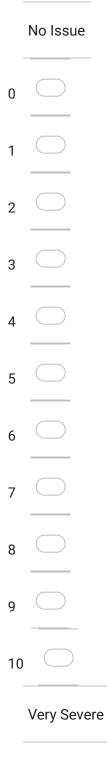
# 81. Problems with fertility?



82. Problems with miscarriage?

Yes		
No		
Other:	 	 

#### 83. Breast cysts, lumps or mastitis?



# 84. Menopause?



85. Have you had/have breast or uterine cancer?

Mark only one oval.

Yes

86. Have had a hysterectomy?

Mark only one oval.

🔵 Yes

🔵 No

87. If yes, how many years ago?

Skip to question 88

**Skin Health Conditions** 

If not applicable a response is not needed.

#### 88. Acne?

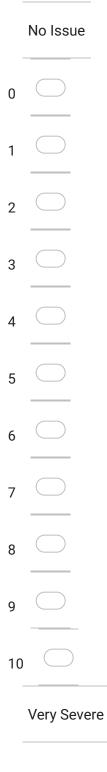
Mark only one oval.

No Issue

#### 89. General unhealthy skin?



# 90. Oily, dry or itchy skin?



#### 91. Eczema – psoriasis or cracking skin?



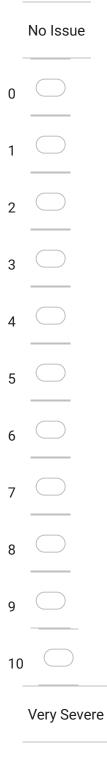
#### 92. Cysts, warts, moles, liver spots, fungus growths?



#### 93. Rashes or vesicles?



# 94. Herpes or shingles?



95. Boils?

Mark only one oval.

No Issue

**Client Forms** 

#### 96. Sores that are slow to heal?



# 97. Bruise easily?

Mark only one oval.

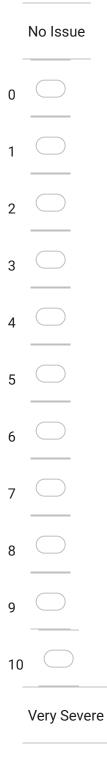


Immune System

98. Please describe any food allergies you may have.

99. Please describe any chemical sensitivities you may have.

# 100. Hay fever?



### 101. Asthma?

Mark only one oval.

# No Issue

- 0
- 1
- 2
- 3
- 4
- \_\_\_\_\_
- 5
- 6
- \_\_\_\_\_
- 7
- 8
- 9
- 10

Very Severe

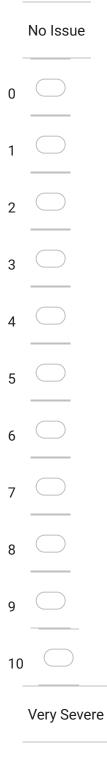
# 102. Frequent colds or flus?



### 103. Frequent sore throats?



# 104. Frequent laryngitis?



# 105. Frequent cough?

Mark only one oval.

# No Issue 0 1 2 3 4 5 6 7 8 9

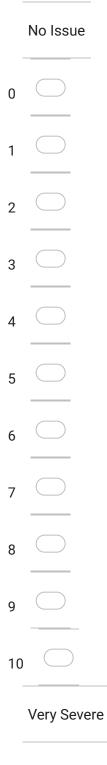
Very Severe

10

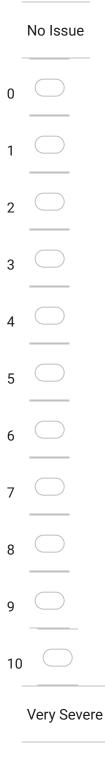
# 106. Chronic chest condition?



### 107. Post nasal drip?



# 108. Frequent sinus problems?



# 109. Frequently 'stuffy'?

Mark only one oval.

# No Issue

- 0
- \_\_\_\_\_
- 1
- 2
- 3
- \_\_\_\_\_
- 4
- 5
- 6
- \_\_\_\_\_
- 7
- 8
- \_\_\_\_\_
- 9
- 10

Very Severe

### 110. Often have to spit up phlegm?



### 111. Frequent earaches or discharges?



### 112. Hair or nail problems?



### 113. Weakness or exhaustion?



### 114. Do you have skin or genital warts?

Mark only one oval.



**Digestion Issues** 

### 115. Stomach Ulcers?

Mark only one oval.

# No Issue 0 1 2 3 4 5 6 7 8 9 10 Very Severe

### 116. Liver or gall bladder problems?



# 117. Are you diabetic?



### 118. Eat when you are nervous?



### 119. Have black tarry or bloody stools?



# 120. Suffer from Constipation?

Mark only one oval.

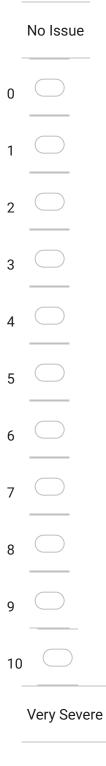
121. Use laxatives

Mark only one oval.

O Yes

🔵 No

# 122. Diarrhea or colitis?



# 123. Indigestions, gas or bloat?



### 124. Heartburn?



### 125. Hemorrhoids, fissures, polyps?



126. Ever had an intestinal worm or itchy rectum?



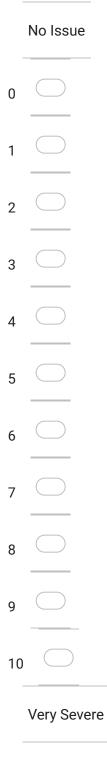
### 127. Gout?



# 128. Frequent nausea?

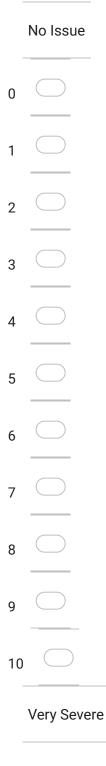


### 129. Excessive appetite?



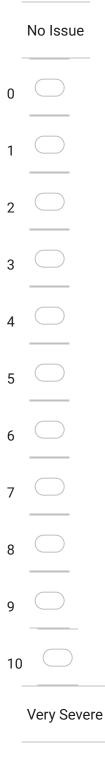
### 130. Desire to vomit after eating?

Mark only one oval.



Neuro/musculo/skeletal Issues

### 131. Suffer rheumatoid arthritis?



132.	Any part of your body experience numbness/tingling?
133.	Neck complaints?
134.	Shoulder complaints?
135.	Mid-back complaints?

136.	Low back complaints?
137.	Hip complaints?

# 138. Have a spinal curvature?

Mark only one oval.

### 139. Suffer from muscles spasms?



# 140. Muscles frequently sore?

Mark only one oval.

No Issue

3

- 4
- 5

6

7

- 8
- 9 0

\_\_\_\_\_

10

### 141. Muscle weakness?



# 142. Joints stiff in the morning?

Mark only one oval.

No Issue

0

- \_\_\_\_
- 1
- 2
- 3
- \_\_\_\_\_
- 4
- 5
- 6
- 7
- \_\_\_\_\_
- 8
- 9
- 10

# 143. Suffer from painful feet?

Mark only one oval.

No Issue

0

- 1
- 2
- 3
- 4
- \_\_\_\_\_
- 5
- 6
- 7
- 8
- \_\_\_\_\_
- 9
- 10

# 144. Suffer from heel spurs?

Mark only one oval.

No Issue

0

- 1
- 2
- 3
- \_\_\_\_\_
- 4
- 5
- 6
- \_\_\_\_\_
- 7
- 8
- 9
- \_\_\_\_\_
- 10

# 145. Troubles by corns?

Mark only one oval.

No Issue

0

- 1
- 2
- 3
- 4
- \_\_\_\_\_
- 5
- 6
- 7
- \_\_\_\_\_
- 8
- 9
- 10

#### 146. Sciatica?



#### 147. Sciatica?



148. Headaches? Type: sinus/tension/migraine – where do they start?

# 149. Jaws problems (TMJ)?

Mark only one oval.

# No Issue

- 0
- \_\_\_\_\_
- 1
- 2
- \_\_\_\_\_
- 3
- 4
- \_\_\_\_\_
- 5
- 6
- \_\_\_\_\_
- 7
- 8
- \_\_\_\_\_
- 9
- 10

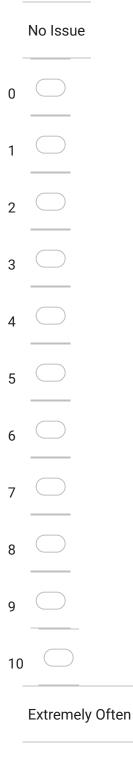
#### 150. Tremors, twitches or neurological diseases?

Mark only one oval.



**Urinary Issues** 

# 151. Frequent urination?



#### 152. Bed wetter?



# 153. Have lost control of bladder or dribble when sneeze or laugh?



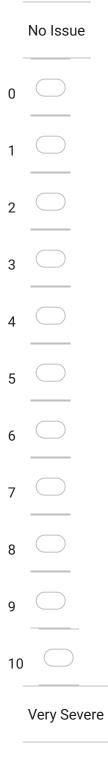
# 154. Painful urination?



### 155. Difficulty in starting stream?



# 156. Frequent kidney or bladder infections?

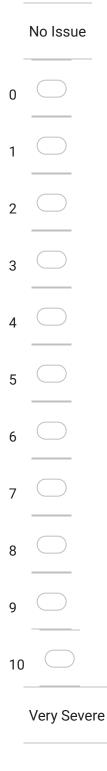


# 157. Suffer from kidney stones?



# 158. Blood in your urine?

Mark only one oval.



**Behavioral Ailments** 

#### 159. Nervousness?

Mark only one oval.

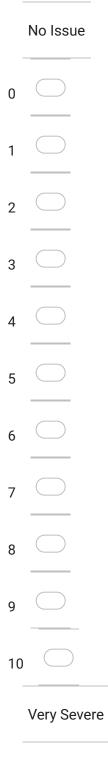
# 160. Agoraphobia – fear of closed spaces?

Mark only one oval.

#### 161. Manic depressive or severe personality shifts?



#### 162. Any severe mental or emotional traumas?



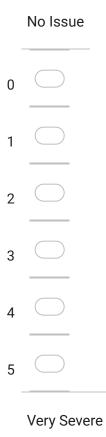
# 163. Grief or guilt?

Mark only one oval.



https://docs.google.com/forms/d/18tY3mL9S10vcnUZVYI-GM6X49hSdNoTIKI295upYjX8/edit

### 164. Insomnia?



# 165. Do you feel under emotional stress?



#### 166. More than the occasional feeling of depression?

Mark only one oval.



# Family Medical History

167. Blood Pressure

168.	Cancers
169.	Allergies/Asthma;
170.	Diabetes
171.	Coronary Disease

Any relevant information you wish to share?
Services Requested
Specified Treatments Requested for all of the Above?
Please describe any relevant health events and give either a date or a estimated time that has passed since.

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# Google Forms

3/9/23, 11:48 AM

**Client Forms**