

# Client Forms

## Intake Survey

\* Required

1. Name: \*

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2. Address:

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3. City:

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4. State:

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5. Zip:

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6. Email:

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7. Cell Phone:

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8. Home Phone:

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9. Birth Date:

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*Example: January 7, 2019*

10. Reason For Consultation:

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11. Health Care Professionals Consulted in the Past Year:

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*Skip to question 12*

## Lifestyle

### Lifestyle Questions

12. Occupation

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13. Hours per week spent:

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14. Time spent sitting at work:

*Mark only one oval.*

☐ 1-2

☐ 2-4

☐ 4-6

☐ 6-8

☐ 8-10

☐ Other: 

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15. Time spent sitting during free time on average:

*Mark only one oval.*

☐ 1-2

☐ 2-4

☐ 4-6

☐ 6-8

☐ 8-10

☐ Other: 

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## 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:

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## 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?

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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.

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23. What are the causes of your stress?

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24. How well do you manage your stress

Mark only one oval.

Not at all

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Completely

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!)

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26. How often do you prepare your own food?

*Mark only one oval.*

- ☐ 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.

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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





*Mark only one oval.*

- ☐ 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	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
<b>BEER or COOLER</b>	
<b>12 oz.</b>  <b>~5% alcohol</b>	<ul style="list-style-type: none"> <li>• 12 oz. = 1</li> <li>• 16 oz. = 1.3</li> <li>• 22 oz. = 2</li> <li>• 40 oz. = 3.3</li> </ul>
<b>MALT LIQUOR</b>	
<b>8.9 oz.</b>  <b>~7% alcohol</b>	<ul style="list-style-type: none"> <li>• 12 oz. = 1.5</li> <li>• 16 oz. = 2</li> <li>• 22 oz. = 2.5</li> <li>• 40 oz. = 4.5</li> </ul>
<b>TABLE WINE</b>	
<b>5 oz.</b>  <b>~12% alcohol</b>	<ul style="list-style-type: none"> <li>• a 750 mL (25 oz.) bottle = 5</li> </ul>
<b>80-proof DISTILLED SPIRITS</b>	
<b>1.5 oz.</b>  <b>40% alcohol</b>	<ul style="list-style-type: none"> <li>• 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> </ul> <p>*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.</p>

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

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

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

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### 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.

No Issue

0 ☐

1 ☐

2 ☐

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4 ☐

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6 ☐

7 ☐

8 ☐

9 ☐

10 ☐

Very Severe

39. Degree you are underweight

Mark only one oval.

No Issue

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Very Severe

40. Heart problems

Mark only one oval.

No Issue

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

Very Severe



41. Experience rapid heartbeats

Mark only one oval.

No Issue

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Very Severe

42.   Aware of skipping beats

*Mark only one oval.*

No Issue

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Very Severe

43. Blood pressure problems

Mark only one oval.

No Issue

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Very Severe

44. Circulatory problems

Mark only one oval.

No Issue

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Very Severe

45. Episodes of dizziness?

Mark only one oval.

No Issue

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Very Severe

46. Cold hands or feet?

Mark only one oval.

No Issue

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Very Severe

47. Varicose veins?

Mark only one oval.

No Issue

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Very Severe

48. Seems to have excessive thirst?

Mark only one oval.

No Issue

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Very Severe



49. Usually tired most of the time?

Mark only one oval.

No Issue

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Very Severe

Mark only one oval.

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Mark only one oval.

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Mark only one oval.

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11/11/2016

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53. Eye condition?

Mark only one oval.

No Issue

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Very Severe

54. Sensitive to bug bites?

Mark only one oval.

No Issue

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Very Severe

55. Loss of memory?

Mark only one oval.

No Issue

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Very Severe

56. Confusion?

Mark only one oval.

No Issue

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Very Severe



57.    Get lightheaded when you stand quickly?

Mark only one oval.

No Issue

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Very Severe

58. Bright lights bothersome to eyes?

Mark only one oval.

No Issue

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10 ☐

Very Severe

59.    Trouble falling asleep?

*Mark only one oval.*

No Issue

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Very Severe

60. Wake at night at regular times?

Mark only one oval.

No Issue

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Very Severe

61. Sweat for no reason at night?

Mark only one oval.

No Issue

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Very Severe

62. Wake up tired after a good nights sleep?

Mark only one oval.

No Issue

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Very Severe

63. Frequently feel hot?

Mark only one oval.

No Issue

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Very Severe

64. Frequently feel cold?

Mark only one oval.

No Issue

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Very Severe



65. Eating relieves fatigue?

Mark only one oval.

No Issue

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Very Severe

66.    Feel shaky when hungry?

*Mark only one oval.*

No Issue

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Very Severe

67. Poor concentration?

Mark only one oval.

No Issue

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Very Severe

68. Sexual problems?

Mark only one oval.

No Issue

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Very Severe

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?

Mark only one oval.

No Issue

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Very Severe

71. Impotency or decrease sexual desire?

Mark only one oval.

No Issue

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1 ☐

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Very Severe

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?

Mark only one oval.

No Issue

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Very Severe

74. Take birth control pills?

Mark only one oval.

No Issue

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Very Severe

75. Suffer from PMS?

Mark only one oval.

No Issue

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Very Severe

76. Retain fluid during period?

Mark only one oval.

No Issue

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Very Severe

Mark only one oval.

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78. Suffer from frequent yeast infections?

Mark only one oval.

No Issue

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Very Severe

79. Intercourse is painful?

Mark only one oval.

No Issue

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Very Severe

80. Diminished sex drive?

Mark only one oval.

No Issue

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Very Severe



81. Problems with fertility?

Mark only one oval.

No Issue

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Very Severe

## 82. Problems with miscarriage?

*Mark only one oval.*

☐ Yes

☐ No

☐ Other: \_\_\_\_\_

83. Breast cysts, lumps or mastitis?

Mark only one oval.

No Issue

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Very Severe

Mark only one oval.

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

*Mark only one oval.*

☐ Yes

☐ No

86. Have had a hysterectomy?

*Mark only one oval.*

☐ Yes

☐ No

87. If yes, how many years ago?

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*Skip to question 88*

### Skin Health Conditions

If not applicable a response is not needed.

88. Acne?

Mark only one oval.

No Issue

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Very Severe

89. General unhealthy skin?

Mark only one oval.

No Issue

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Very Severe

90. Oily, dry or itchy skin?

Mark only one oval.

No Issue

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Very Severe



91. Eczema – psoriasis or cracking skin?

Mark only one oval.

No Issue

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Very Severe

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

Mark only one oval.

No Issue

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Very Severe

93. Rashes or vesicles?

Mark only one oval.

No Issue

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Very Severe

94. Herpes or shingles?

Mark only one oval.

No Issue

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Very Severe

95. Boils?

Mark only one oval.

No Issue

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Very Severe

96. Sores that are slow to heal?

Mark only one oval.

No Issue

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Very Severe

97. Bruise easily?

Mark only one oval.

No Issue

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Very Severe

Immune System

98. Please describe any food allergies you may have.

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99. Please describe any chemical sensitivities you may have.

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100. Hay fever?

Mark only one oval.

No Issue

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Very Severe

101.   Asthma?

*Mark only one oval.*

No Issue

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Very Severe

102.    Frequent colds or flus?

*Mark only one oval.*

No Issue

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Very Severe

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103. Frequent sore throats?

Mark only one oval.

No Issue

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Very Severe

104.    Frequent laryngitis?

*Mark only one oval.*

No Issue

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Very Severe

105. Frequent cough?

Mark only one oval.

No Issue

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Very Severe

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106. Chronic chest condition?

*Mark only one oval.*

No Issue

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Very Severe

107. Post nasal drip?

Mark only one oval.

No Issue

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Very Severe



108. Frequent sinus problems?

Mark only one oval.

No Issue

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Very Severe

109. Frequently ‘stuffy’?

Mark only one oval.

No Issue

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Very Severe

110. Often have to spit up phlegm?

Mark only one oval.

No Issue

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Very Severe

111. Frequent earaches or discharges?

Mark only one oval.

No Issue

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Very Severe

112. Hair or nail problems?

Mark only one oval.

No Issue

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Very Severe

113. Weakness or exhaustion?

Mark only one oval.

No Issue

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Very Severe

114. Do you have skin or genital warts?

Mark only one oval.

No Issue

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Very Severe

Digestion Issues

115. Stomach Ulcers?

Mark only one oval.

No Issue

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☐

1

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Very Severe



116. Liver or gall bladder problems?

Mark only one oval.

No Issue

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Very Severe

117. Are you diabetic?

Mark only one oval.

No Issue

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Very Severe

118.    Eat when you are nervous?

*Mark only one oval.*

No Issue

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Very Severe

119. Have black tarry or bloody stools?

Mark only one oval.

No Issue

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Very Severe

120. Suffer from Constipation?

Mark only one oval.

No Issue

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Very Severe

121. Use laxatives

*Mark only one oval.*

☐ Yes

☐ No

122.     Diarrhea or colitis?

*Mark only one oval.*

No Issue

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Very Severe

123. Indigestions, gas or bloat?

Mark only one oval.

No Issue

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Very Severe



124. Heartburn?

Mark only one oval.

No Issue

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Very Severe

125. Hemorrhoids, fissures, polyps?

Mark only one oval.

No Issue

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Very Severe

126. Ever had an intestinal worm or itchy rectum?

*Mark only one oval.*

☐ Yes

☐ No

127. Gout?

Mark only one oval.

No Issue

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Very Severe

128. Frequent nausea?

Mark only one oval.

No Issue

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Very Severe

129. Excessive appetite?

Mark only one oval.

No Issue

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Very Severe

130. Desire to vomit after eating?

Mark only one oval.

No Issue

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Very Severe

Neuro/musculo/skeletal Issues

131. Suffer rheumatoid arthritis?

Mark only one oval.

No Issue

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Very Severe



132. Any part of your body experience numbness/tingling?

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133. Neck complaints?

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134. Shoulder complaints?

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135. Mid-back complaints?

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136. Low back complaints?

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137. Hip complaints?

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138. Have a spinal curvature?

Mark only one oval.

No Issue

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Very Severe

139. Suffer from muscles spasms?

Mark only one oval.

No Issue

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Very Severe

140. Muscles frequently sore?

Mark only one oval.

No Issue

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Very Severe

141. Muscle weakness?

Mark only one oval.

No Issue

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Very Severe

142. Joints stiff in the morning?

Mark only one oval.

No Issue

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Very Severe

143. Suffer from painful feet?

Mark only one oval.

No Issue

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Very Severe



144. Suffer from heel spurs?

Mark only one oval.

No Issue

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Very Severe

145. Troubles by corns?

Mark only one oval.

No Issue

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Very Severe

146.    Sciatica?

*Mark only one oval.*

No Issue

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Very Severe

147.    Sciatica?

*Mark only one oval.*

No Issue

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Very Severe

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

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149. Jaws problems (TMJ)?

Mark only one oval.

No Issue

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Very Severe

150. Tremors, twitches or neurological diseases?

Mark only one oval.

No Issue

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Very Severe

Urinary Issues

151. Frequent urination?

Mark only one oval.

No Issue

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Extremely Often



152. Bed wetter?

Mark only one oval.

No Issue

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Extremely Often

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

Mark only one oval.

No Issue

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Very Severe

154. Painful urination?

Mark only one oval.

No Issue

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Very Severe

155.    Difficulty in starting stream?

*Mark only one oval.*

No Issue

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Very Severe

156.    Frequent kidney or bladder infections?

*Mark only one oval.*

No Issue

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Very Severe

157. Suffer from kidney stones?

Mark only one oval.

No Issue

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Very Severe

158. Blood in your urine?

Mark only one oval.

No Issue

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Very Severe

Behavioral Ailments

159. Nervousness?

Mark only one oval.

No Issue

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Very Severe



160. Agoraphobia – fear of closed spaces?

Mark only one oval.

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Very Severe

161. Manic depressive or severe personality shifts?

Mark only one oval.

No Issue

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Very Severe

162. Any severe mental or emotional traumas?

Mark only one oval.

No Issue

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Very Severe

163. Grief or guilt?

Mark only one oval.

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Very Severe

164. Insomnia?

Mark only one oval.

No Issue

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Very Severe

165. Do you feel under emotional stress?

Mark only one oval.

No Issue

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Very Severe

166. More than the occasional feeling of depression?

Mark only one oval.

No Issue

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Very Severe

Family Medical History

167. Blood Pressure

168. Cancers

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169. Allergies/Asthma;

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170. Diabetes

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171. Coronary Disease

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172. Any relevant information you wish to share?

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### Services Requested

173. Specified Treatments Requested for all of the Above?

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174. Please describe any relevant health events and give either a date or a estimated time that has passed since.

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