Intake Questionnaire

This form is fillable. Once complete, please save it, then return by email as an attachment.

Thank you for your interest in receiving a nutritional assessment. The assessment includes:

- An analysis of nutritional status
- An evaluation of the combined effects of lifestyle, environmental and emotional stressors

This questionnaire will help to identify the potential relationship between traumas that have been sustained and their effects: ie chemicals, diet, radiation, and stress/emotions. Please be as honest and thorough as possible.

Name: _____

Address: _____ City: _____

Postal Code: _____ E mail: _____

Home: # (__) _____ Bus: # (___) _____

Referred By: _____ Blood Type: A☐ B☐ AB☐ O☐

Date of birth: _____ Age: _____ Weight: _____ Height: _____
month day year

Occupation: _____

Past experience with other practitioners: (i.e. Chiropractor, Naturopath, Therapist, Homeopath, Massage)

_____

List one to five health goals you would like to attain for yourself, in order of priority: (How long have these been a concern to you?)

1. _____
2. _____
3. _____
4. _____
5. _____

"I haven't felt well since" _____

What do you believe, or suspect, is the reason for your condition? _____

_____

Recent Diagnosis: _____

Surgeries: Date:

_____ _____

_____ _____

_____ _____

Past conditions or other health information you would like us to know, with dates. Include Childhood Illnesses. Please use separate sheet or record on back of this sheet.

List any vaccinations that you have had including flu shots: Date

_____ _____
_____ _____
_____ _____
_____ _____

What physical trauma/accidents have you experienced?

_____
_____

Family Health History: (Mother/Father Siblings etc...)

_____
_____
_____
_____
_____
_ _____

List any medications you are taking **now or have in the past**.

Medication	**Reason**	**How long**

List any supplements you are currently taking.

Supplements	**Amount**	**How long**

Do you consume any of the following?

How much?

Black Tea ☐ Green Tea ☐ Coffee ☐ Herbal Tea ☐ Alcohol ☐ Water ☐ Fruit Juice ☐ Soda Pop ☐

Sugar/artificial sweetener ☐ Milk ☐Cream ☐ Margarine ☐ Butter ☐ Cheese ☐

Do you smoke now? ☐

In the past? ☐ For how long? ☐ When did you quit? ☐

Allergies, you know of?

Foods you crave?

Exercise:

What Kind:

Frequency:

How is your concentration/focus?

Bowel movements: # per day? - Type, please explain:

(i.e. Strained, loose, soft, hard, very thin, diarrhea, explosive, constipated, undigested food, blood or mucus in stool)

What time do you go to bed? ☐ What time do you get up? ☐

Restless sleeper? ☐ Fall asleep easily? ☐

What position do you sleep in? ☐ Wake up during the night? ☐ Feel rested when waking? ☐

Is your weight stable or up/down? ☐ Constantly dieting? ☐ Do you snore? ☐

Do you have sleep apnea? ☐

Menstrual Cycle:

Regular? ☐ Cramping? ☐ PMS? ☐

Birth control pills? ☐ Hormone replacement? ☐ Frequent urination? ☐

Yeast/Bladder Infections? ☐ Last Period: ☐

Prostate enlargement: ☐

Teeth:

Amalgam/Silver fillings? How man?

Root canals and how many?
Crowns or other metals
(braces, retainers, partials)?

Do you have any tattoos? If so, how many?

Previous occupation(s)?

_____

Do you have a high stress job or stressful relationship/situation?

_____

_____

What emotional trauma/events have you experienced?

_____

_____

_____

What do you do to manage/relieve your stress? What are your hobbies, now and previous?

_____

_____

_____

Do you use any of the following items? If so, which ones and how much? *(use space below)*

What:	Check if Yes	How often?	What:	Check if Yes	How often?
Cell phone	☐		Cookware	☐	
Cordless phone	☐		Electric blanket	☐	
Computer	☐		Waterbed	☐	
Microwave	☐		Antiperspirant	☐	
Aluminium	☐		Perfume	☐	
Hairspray	☐		Pesticides/Lawn/flower or veg garden	☐	

Where have you lived?

_____

_____

How old is your home? Remodeling/construction/new carpets/paint?

_____

_____

Are there hydro lines or transformers near your home or work?

_____

What could get in the way of your plan of action?

_____

_____

_____

Please complete a 3 - 4 day Daily Food Record on the chart provided.

This information is provided for a nutritional assessment. I understand that the information I am seeking is of a nutritional nature and <u>not</u> a medical diagnosis.

Signature: _____ **Date:** _____

Daily Food Diary Log: Please record your food and drink consumption over a 4 –7 day period and note how you feel, (tired, gas, bloating, nausea, constipation, diarrhea, aching joints etc.).

Meal	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast Time:							
Snack Time:							
Lunch Time:							
Snack Time:							
Dinner Time:							
Snack Time:							
Supplements & How I feel							