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Health Evaluation Intake Form

Our ability to draw effective conclusions about your current nutritional and health status as well as how to improve it, depends on your ability to comprehensively, thoughtfully and accurately complete this intake form. Health issues are commonly triggered by myriad factors. Our goal is to help you get to the root of any underlying causes so that we can help you to achieve your goals!

Do not fill out this form in your web browser, it will not save your responses! Save it to your computer first and then open with Adobe Acrobat Reader or Apple Preview.

Contact Information

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Country _____

Phone (Day) _____ Phone (Night) _____ Phone (Cell) _____

Email _____ Referred by _____

Statistics

Age _____ Birth date _____ Gender? ❑ Male ❑ Female

Birth weight (if known) _____ Current weight _____ Ideal weight _____

Weight one year ago _____ Blood type _____

How were you born? ❑ Vaginal ❑ C-section

How were you nursed? ❑ Breast-fed ❑ Bottle-fed

Family/living situation

Children (if yes, list) _____

Occupation _____

Exercise/recreation activities _____

_____

History

Have you lived or traveled outside the United States? ❑ Yes ❑ No

If yes, when and where? _____

_____

Have you or your family recently experienced any major life changes? ❑ Yes ❑ No

If yes, please comment._____

_____

Have you experienced any major losses in life? ❑ Yes ❑ No

If yes, please comment._____

_____

How much time have you had to take off from work or school in the last year?

❑ 0 to 2 days ❑ 3 to 14 days ❑ More than14 days

Health Concerns

What are your main health concerns? Describe in detail, including the severity of the symptoms. _____

_____

_____

_____

When did you first experience these concerns? _____

_____

_____

_____

How have you dealt with these concerns in the past? (Doctors, self-care, etc.)_____

_____

_____

_____

Have you experienced any success with these approaches?_____

_____

_____

_____

What other health practitioners are you currently seeing? (Name, specialty, phone)_____

_____

_____

_____

How often have you taken antibiotics? (Infancy, childhood, teen, adulthood)

List any medications you are currently taking:

List any vitamins, minerals, herbs and nutritional supplements you are currently taking:

Have any family members had similar problems?

Nutritional Status

Are there any foods that you avoid because of the way they make you feel? (If yes, please name the food and the symptom)

Do you have symptoms immediately after eating, like bloating, gas, sneezing or hives? (If yes, please explain)

Are you aware of any delayed symptoms after eating certain foods, such as: fatigue, muscle aches, sinus congestion, etc? (If yes, please explain)

Are there foods that you crave? (If yes, please explain)

Describe your diet at the onset of your health concerns.

Which of the following foods do you consume regularly?

❑ Soda ❑ Diet Soda ❑ Refined Sugar ❑ Alcohol ❑ Fast Food

❑ Gluten (wheat, rye, barley) ❑ Dairy (milk, cheese, yogurt) ❑ Coffee

Are you currently on a special diet?

❑ Ovo-lacto ❑ Diabetic ❑ Dairy restricted/Dairy free ❑ Vegetarian

Describe any other special diets not listed above. _____

What percentage of your meals are home-cooked? _____

Is there anything else we should know about your current diet, history or relationship to food?_____

Intestinal Status

Please take a moment to relay a bit of information about your bowel movements.

Frequency:

❑ More than 3 times per day ❑ 1 to 3 times per day ❑ Not regularly ❑ Everyday

Consistency: Check all that apply

❑ Soft & well formed ❑ Often float ❑ Difficult to pass ❑ Diarrhea ❑ Thin, long or narrow

❑ Small and hard ❑ Loose but not watery ❑ Alternating between hard and loose

Color: Check all that apply

❑ Medium brown ❑ Very dark or black ❑ Greenish ❑ Blood is visible ❑ Variable

❑ Yellow, light brown ❑ Chalky colored ❑ Greasy, shiny

Do you experience intestinal gas? If so, please explain _____

Medical Status

Please check any of the following conditions that apply to your history: Please check all that apply.

❑ Cancer ❑ Heart disease ❑ Hepatitis ❑ Venereal Disease ❑ Diabetes

❑ High Blood Pressure ❑ High Cholesterol ❑ Kidney Disease ❑ Thyroid Disease ❑ Depression

❑ Asthma ❑ Allergies ❑ Anemia ❑ Chronic Yeast Infections ❑ Other (describe below)

Briefly describe your symptoms, chosen treatment(s), and dates: _____

_____

_____

_____

Health Hazards

Have you ever been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

❑ Yes ❑ No

Do odors affect you? ❑ Yes ❑ No

Are you or have you been exposed to second-hand smoke? ❑ Yes ❑ No

Do you have mercury amalgam fillings? ❑ Yes ❑ No

Lifestyle History

Have you had period of eating junk food, bing eating or dieting? _____

_____

List any known diet that you have been on for a significant amount of time. _____

_____

Have you used or abused alcohol, drugs, medications, tobacco, or caffeine? Do you currently? _____

How do you handle stress? _____

_____

_____

Describe your sleep patterns. Do you get to sleep easily? Do you stay asleep? How many hours do you average per night? _____

_____

For Women Only

How are/were your menses? _____

Do/did you have PMS? ❑ Yes ❑ No

Painful Periods? If yes, please explain. _____

In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability? _____

Have you experienced any yeast infections or urinary tract infections? _____

Have you/do you currently take birth control pills? _____

Have you had any problems with conception or pregnancy? _____

Are you taking any hormone replacement therapy or hormonal supportive herbs? _____

Mental Health Status

How are your moods in general? Do you experience more than you would like of anxiety, depression or anger? __

On a scale of 1 - 10 with 1 being the worst and 10 being the best, select your usual level of energy.

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

At what point in your life did you feel your best? Why? _____

Other

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain if no. _____

Who in your family or on your health care team will be most supportive of you making dietary changes?_____

Please describe any other information you think would be useful in helping to address your health concerns. ___

What are your health goals and aspirations? Though it may seem odd, please consider why you might want to achieve these goals for yourself. _____

Thank you for completing the health evaluation intake form.

Print