Client Intake Form

Name:	Age	Date
Date of Birth	Email	
Address		
City	State	Zip
Cell Phone	Other Phone (Home/Work)	
Easiest place to reach you?	May we leave a message?	
Occupation	Employer	
Emergency Contact	Relationship	Cell
How did you hear about our practice?		
Gender Identity	Height	Current Weight
Ideal Weight	Weight One Year Ago	

Are you currently under the care of a physician or other healthcare professionals? If yes, please give name & list conditions

Medications or Supplements

What do you take?

Side effects or problems?
▢Yes
▢No

If yes, describe

Have you used any of these regularly or for an extended time?

NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin

▢ Yes

▢ No

NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin

▢ Yes

▢ No

Tylenol (acetaminophen)?

▢ Yes

▢ No

Acid - blocking drugs (Zantac, Prilosec, Nexium, etc.)?

▢ Yes

▢ No

Stress

Do you feel you have a high amount of stress in your life?
☐ Yes
☐ No

Is it difficult to manage the stress?
☐ Yes
☐ No

Do you use relaxation techniques?
☐ Yes
☐ No

Which techniques do you use? (Check all that apply):
☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐Prayer ☐ Other: How often?

Have you ever sought counseling? ☐Yes ☐ No Are you currently in therapy? ☐Yes ☐ No

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☐ Yes ☐ No

What are your hobbies or leisure activities?

Relationships

Marital status: ☐ Single ☐Married ☐ Divorced ☐Long-Term Partner ☐ Widow/er

With whom do you live? (Include family/friends/pets)

Do you have resources for emotional support? ☐ Yes ☐ No (Check all that apply):
☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other

Do you have a religious or spiritual practice? ☐ Yes ☐ No If yes, what kind?

How well have things been going for you?

(Circle on a scale of 1-10, or check N/A if not applicable)

Category	N/A	Poorly				Fine					Very Well
Overall		1	2	3	4	5	6	7	8	9	10
At school		1	2	3	4	5	6	7	8	9	10
In your job		1	2	3	4	5	6	7	8	9	10
In your social life		1	2	3	4	5	6	7	8	9	10
With close friends		1	2	3	4	5	6	7	8	9	10
With sex		1	2	3	4	5	6	7	8	9	10
With dating		1	2	3	4	5	6	7	8	9	10
With your children		1	2	3	4	5	6	7	8	9	10
With your parents		1	2	3	4	5	6	7	8	9	10
With your spouse/partner		1	2	3	4	5	6	7	8	9	10

Head Trauma? ▢ Yes ▢ No
If yes, please describe:

Food Poisoning? ▢ Yes ▢ No
If yes, please describe:

Spouse/Partner's Name: Health Issues?

Children's names/ages: Health Issues?

Current Health Concerns

Concern	Mild	Mod	Severe	Prior Treatment//Approach	Excellent	Good	Fair

Surgical History and/or Major Medical Procedures

Antibiotics ▢ Present ▢ Past

Oral Steroids (cortisone, prednisone, etc. ▢ Present ▢ Past

Allergies

Name of Medication/Supplement/Food	Reaction

Lifestyle Review

Exercise - Current Exercise Program:

Activity	Type	# Of times per week	Time/Duration (minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure(e.g., golf)			
Other			

Sleep Questionnaire

Rate your sleep quality. Check all that apply: ▢ Wake up tired▢ Nightmares/Terrors▢ Restless Legs ▢ Teeth Grinding ▢Sleep Apnea▢ Snoring ▢ Difficulty falling asleep ▢Toss and turn ▢Sleepwalk ▢ Sleep talk ▢Wake up during the night(usually at: _____) ▢ Other:

What time do you usually go to sleep on weekdays (workdays)?_____ Hours you sleep per night?_____

What time do you usually go to sleep on weekends (days off)?_____Hours you sleep per night?_____

How long does it take you to go to sleep? ▢0-5 minutes ▢ 5-15 minutes ▢ 15-30 minutes ▢30-60 minutes ▢ 60+ minutes

How long has this been happening? ▢Less than 1 month ▢Longer than 1 month

How long do you stay asleep? ▢Just minutes ▢1-2 hours, wake up, but then return to bed ▢Awake nightly at 3 am

Number of times wake up on a given night:_____ How long could you sleep? ▢<7 hours ▢7-8 hrs. ▢9-11 hrs. ▢11+

My sleep position is:☐ On back ☐On stomach ☐On side ☐No single position used

When are you hungry after you awake? ☐ Within 30 minutes or less ☐Between 30 min to 2 hours ☐2+ hours after

How often do you take a nap during the day? ☐Never ☐1x each week ☐ 2x each week ☐ 3+x each

Have you had any Adrenal hormonal testing performed?☐ Yes ☐No ☐ I don't know

Do you take sleep medications or supplements? ☐ No ☐ Yes (list) _____

Diet Review

How many servings do you eat in a typical week of these foods: Fruits (not juices)_____Vegetables_____ Fish_____
Legumes_____Red Meat_____ Fish_____ Dairy_____Dairy Alternatives_____ Nuts & Seeds_____ Fats & Oils_____

Cans of Soda (regular and diet)_____ Sweets (candy, cookies, cake, ice cream, etc.)_____

Do you drink caffeinated beverages? ☐ No ☐ Yes If yes check amounts:

Coffee (cups per day)	☐ 1	☐2-4	☐>4
Tea (cups per day)	☐1	☐2-4	☐>4
Caffeinated Sodas (cups per day)	☐1	☐ 2-4	☐ >4

Dental History

Check if you have any of the following, and provide number if applicable: ☐Silver mercury fillings ___☐Gold fillings ____
☐Root canals _____☐ Implants ____☐Caps/Crowns ____☐Tooth pain _____☐Bleeding gums _____☐Gingivitis ___
☐Problems with chewing _____☐Other dental concerns, explain: _____

Have you had any mercury fillings removed? ☐Yes ☐No
If yes, when: _____ How many fillings as a kid? _____ Do you brush regularly? ☐Yes ☐No

Do you floss regularly? ☐ Yes ☐No

Environmental/Detoxification History

Do any of these significantly affect you? ☐Cigarette smoke ☐Perfume/colognes ☐Auto exhaust fumes ☐Other: _____

In your work or home environment are you regularly exposed to: (Check all that apply)
☐ Mold ☐Water leaks ☐ Renovations ☐Chemicals ☐Electromagnetic radiation ☐Damp environments ☐Carpets/rugs ☐Old paint
☐Stagnant/stuffy air ☐Smokers ☐Pesticides ☐Herbicides ☐Harsh chemicals (solvents,/glues/gas/acids ☐ Cleaning chemicals
☐Heavy metals (lead, mercury, etc.) ☐ Paints ☐Airplane travel ☐Other: _____

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No
If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? ☐Yes ☐ No If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

Men's History (For Men Only) (Check box if applicable)

☐Testicular mass ☐Testicular pain ☐ Prostate enlargement ☐ Prostate infection ☐ Change in sex drive ☐ Impotence
☐ Premature ejaculation ☐ Difficulty obtaining an erection ☐ Difficulty maintaining an erection ☐Loss of control of urine
☐Urinary urgency/hesitancy/change in stream ☐Vasectomy ☐ Nocturia (urination at night) # of times per night _____
☐Sexually transmitted diseases (describe): _____

Screening/Procedures: (If applicable, provide date)
Last PSA test: _____ PSA Level: ☐ 0-2 ☐ 2-4 ☐4-10 ☐ >10

Other tests/procedures (list type and dates)_____
_____

Women's History (For Women Only)

Obstetric History: (Check box and provide number if applicable)
☐ Pregnancies _____☐Miscarriages _____☐ Abortions _____☐ Living children _____☐Vaginal deliveries _____☐Cesarean _____
☐Term births _____☐ Premature birth _____Birth weight of largest baby _____Birth weight of smallest baby _____

Did you develop any problems during or after pregnancy, for example, toxemia (high blood pressure), diabetes, postpartum

depression, issues with breastfeeding, etc.? ☐ Yes ☐ No If yes, please explain: _____

Menstrual History: Age at first period _____Date of last menstrual period _____Length of cycle _____Time between cycles _____
Cramping? ☐ Yes ☐No Pain? ☐ Yes ☐ No

PMS (bloating, breast tenderness, irritability, etc.)?
☐ No ☐Yes, describe:_____ Other problems with your periods (heavy, irregular, spotting, skipping, etc.)?☐ No ☐ Yes, Describe:_____

Use of hormonal **birth control**? ☐Birth control pills ☐ Patch ☐ Nuva ring ☐ Other _____ How long _____
Any problems with hormonal birth control? ☐ No ☐ Yes, Describe:_____
Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in **menopause**? ☐ Yes ☐ NO If yes, age at last period: _____
Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery:_____
Do you currently have symptomatic problems with menopause? (Check all that apply)
☐Hot flashes ☐Mood swings ☐ Concentration/memory problems ☐Headaches ☐ Palpitations ☐ Joint pain ☐ Vaginal dryness
☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine

Are you on **hormone replacement therapy**? ☐ No ☐ Yes, Describe:_____ purpose: _____

Other OBGYN Symptoms: (Check if apply) ☐ Endometriosis ☐ Infertility ☐Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer ☐ Sexually transmitted diseases (describe):_____

Gynecological Screening/Procedures: If applicable, provide date)
Last **Pap** test: _____ ☐Normal ☐Abnormal

Last **mammogram**: _____ ☐ Normal ☐ Abnormal

Last **bone density**: _____Results: ☐ High ☐ Low ☐ Within Normal Range Other tests/procedures:_____

Family History

Check family members that have/had any of the following:

	MOTHER	FATHER	BROTHER (S)	SISTER (S)	CHILDREN	MATERNAL GRANDM	MATERNAL GRANDF	PATERNAL GRANDM	PATERNAL GRANDF
Age (if still alive									
Age at death									
Cancer									
Heart Disease									
Hypertension									
Obesity									
Diabetes									
Stroke									
Autoimmune disease									
Arthritis									
Kidney disease									
Thyroid problems									
Seizures/epilepsy									
Psychiatric disorders									
Anxiety									
Depression									
Asthma									
Allergies									
Eczema									
ADHD									
Autism									
IBS									
Dementia									
Substance abuse									
Genetic disorders									
Other									

OTHER INFORMATION WE NEED TO KNOW: