BREĚZE HOLISTIC

Client Intake Form

Please submit at least 48 hours before your visit to hi.breezeholistic@gmail.com.
Please leave blank anything that doesn't apply to / align with you.

Welcome! I'm really looking forward to working with you. We'll go over everything in our first visit, so if you have special questions or concerns feel free to ask them here. I thoroughly review these forms ahead of your visit to make it most valuable for you. On the last page is a Food & Mood Journal — optional, but very helpful if you want us to take a closer look at your eating and how it may play into your current concerns. Thank you!

Preferred Name:

Full Legal Name:

Phone:

Email:

Preferred contact method:

Age:

Birth Date:

Height: **Weight**:

Pronouns:

Sex Assigned at Birth:

Ethnicity/ies:

Current Health Concerns:

Existing Medical Diagnoses:

Relevant Health History:
Please include any significant illnesses, medications, hospitalizations, and concerns

Relevant Family Health History:

Known Allergies (Food, Medication, Environmental):

Providers Met With in Past Year:

Any topics that are difficult/triggering that you'd like avoided in conversation?

Any history of disordered eating or negative relationship to food?

Occupation:

Interests:

Typical Diet (Food & Drink)
Keep brief! More details can be added to the Food & Mood Journal if you want a more detailed dietary assessment.
Breakfast:
Lunch:
Snacks:
Dinner:
Dessert:
Drinks:

Exercise (+ times/week):

Sleep
Typical hours asleep?
Any insomnia?
Feel rested upon rising?

Stress Level (out of 10)
Work: /10
Personal Life: /10
Current Health: /10

Relaxation/Stress Relief Activities:

Any Regular Relaxant or Stimulant Use:
caffeine, nicotine, alcohol, cannibas (THC or CBD), herbs, fungi, or recreational drugs:

What do you believe you can do to make a difference in your current health status?

What is your readiness level to make changes (be honest!)?:

See Medication and Laboratory Data, next page —>

Current Medications, Supplements + Herbs — add rows as needed *If easier, line them up and take a picture of the front labels, and attach image instead*				
Brand + Name	**Dosage**	**Frequency**	**Duration**	**Reason for Taking**

Recent Laboratory Data — *If easier, send a copy of the lab data instead*	
Marker	**Status / Current Value**

See Symptom Questionnaire, next page —>

Symptom Questionnaire

Point Scale:

0 – Never or almost never have the symptom
1 – Occasionally have it, effect is *not* severe
2 – Occasionally have it, effect is severe
3 – Frequently have it, effect is *not* severe
4 – Frequently have it, effect is severe

HEAD
__ Headaches
__Faintness
__Dizziness
__Insomnia

EYES
__Watery or itchy eyes
__Swollen, reddened, or sticky eyelids
__Bags or dark circles under eyes
__Blurred or tunnel vision
(does not include near or far sightedness)

EARS
___Itchy ears
___Earaches, ear infections
___Drainage from ears

NOSE
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation

MOUTH/THROAT
__Chronic coughing
__Gagging, frequent need to clear throat
__Sore throat, hoarseness, loss of voice
__Swollen or discolored tongue, gums, lips
__Canker sores

SKIN
__Acne
__Hives, rashes, dry skin
__Hair loss
__Flushing, hot flashes
__Excessive sweating

HEART
__Irregular or skipped heartbeat
__Rapid or pounding heartbeat
__Chest Pain

LUNGS
__Chest Congestion
__Asthma, bronchitis
__Shortness of breath
__Difficulty Breathing

DIGESTIVE TRACT
___Nausea, vomiting
___Diarrhea
___Constipation
___Bloated feeling
___Belching, passing gas
___Heartburn
___Intestinal/stomach pain

JOINTS /MUSCLE
___Pain or aches in joints
___Arthritis
___Stiffness or limitation of movement
___Pain or aches in muscle
___Feeling of weakness or tiredness

WEIGHT
___Binge eating/drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water Retention
___Underweight

ENERGY/ACTIVITY
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness

MIND
___Poor Memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___ Slurred speech
___Learning dificulties

EMOTION
___Mood swings
___Anxiety, fear, nervousness
___Anger, irratability, aggressiveness
___Depression

See Consent Form, next page —>
and Diet Diary, last page

Consent Form
&
Disclaimer of Liability

I, _____, hereby acknowledge that Emily Wittenhagen (hereafter, the practitioner) is not a physician or psychiatrist. While the practitioner can administer hypnotherapy and make nutritional diagnoses established by the Academy of Nutrition and Dietetics' Nutrition Diagnostic Terminology, the scope of her consultation services does not include diagnoses of specific illnesses or disorders.

Any mention of medication in the course of consultation is only for the purpose of gathering the health history of the client and checking against recommendations to ensure there are no counter-indications. Any change in prescription or dosage is a decision the client makes with their physician or psychiatrist.

The practitioner's focus of care is on the healing and prevention of illness through the use of natural nutritional, herbal, and theraputic therapies to achieve optimal health and can make use of existing diagnoses in order to recommend interventions. While clients generally experience improvements as a result of these interventions, the practitioner cannot guarantee healing or protection from current or future illness. All decisions are ultimately made by the client.

By signing below, I acknowledge that I understand that the practitioner is a health consultant and not a physician or psychiatrist, and that I should see one of the former if I believe I have a serious medical condition in need of diagnosis or treatment. The practitioner will not be held liable for failure to diagnose or treat an illness, nor will she be liable for failure to prevent future illness.

Lastly, I promise to give the practitioner a complete and accurate account of any medical conditions that I may have and any medications that I am taking.

Client's Signature/Initials_____ Date_____

OR

Proxy's Signature/Initials_____Date_____

Proxy's Relationship to Client_____

Food & Mood Journal

Optional but very helpful if you want us to take a closer look at your food/drink intake and how it may play into your current concerns.

Day 1 Food & Drink	**Status** — symptoms, moods, energy levels, etc
Breakfast **Example**: coffee, yogurt w/ blueberries	**Example**: heartburn, a little anxious, lethargic
Morning Snack	
Afternoon Snack	
Dinner	
Dessert	
Day 2 Food & Drink	**Status** — symptoms, moods, energy levels, etc
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Dessert	
Day 3 Food & Drink	**Status** — symptoms, moods, energy levels, etc
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Dessert	