CLIENT INTAKE & ASSESSMENT FORM

The information provided in this form will be kept strictly confidential and is protected from misuse, loss or unauthorized modification, disclosure or access.

Client Information

Date:

Name: test

Phone:

Email:

Address:

Marital Status: Married Single Divorced Separated Widowed Common Law

Personal Profile Information

Gender: Male Female

Age: _____ **Height:** _____

Weight NOW: _____ **Goal Weight** (if applicable)**:** _____ **Body fat %** _____

Physical Activity

Explain in detail what type of resistance exercises, cardiovascular or sports activities you perform on average during a 7-day period *

Exercise/Activity	Days/week	Duration

Add any further notes here regarding your level of exercise and training:

How would you rate your activity level, including what you do during the day (ie take into

account your job if it is physical in nature). Select one *

Sedentary Moderately Active Active Very Active

Do you feel fatigued after exercise? If so, describe *

Body Type & Diet History

Which of the following statements best describes you?

Check one *

- ☐ I can eat practically anything I want and I don't gain weight.
- ☐ I find it very hard to gain weight.
- ☐ I can lose or gain weight by adjusting my activity level and eating
- ☐ habits. I find it difficult to lose weight.
- ☐ I can gain weight easily and have to watch what I eat.

Have you ever been placed on any type of nutritional program in the past?

Circle one * Yes / No

If yes, by whom and what did it consist of? Please explain below.

What were your results?

What were the biggest challenges?

What is Your Main Health Concern? (describe with symptoms & duration)

When did your health problem first begin?

What else was going on in your life at that time? (Ie change in diet, physical activity, job, relationships, and any additional details you remember.)

What makes you feel worse?

What makes you feel better?

Sleep Profile

What time do you normally go to bed and wake up?

How long does it take you to fall asleep?

Do you wake up feeling rested?

Do you use sleep aids? If so what kind:

Family History & Lifestyle Profile

Do you have children?

What are their ages *

Occupation:

Have you or your family experienced any significant recent life changes? Please explain *

Have you experienced any major losses in life?
Please explain *

Daily Stressors: Rate each on a scale of 1-10

Family _____ Work_____ Health _____ Finances _____ Social _____ Other _____

Family history:

Family Member	Age(s)	Health Status
Mother		
Father		
Sister(s)		
Brother(s)		

Have you ever been hospitalized? If yes, when? Why?

List any surgeries you have had:

Vaccinations and/or Flu shots? Include approximate age.

How have you dealt with your health concerns in the past? Check all that apply *

Doctor

Practitioner (type? _____)

Self care

Dietitian

What other health practitioners are you currently seeing? (list name, specialty)

How often did you take antibiotics as a child & teen?

* Please list infections being treated and approximate ages.

How often did you take antibiotics as an adult?

* Please list infections treated and date estimates.

Psychosocial

	YES	NO
Do you feel less vital than you did one year ago?		
Do you like yourself as you are today?		
Do you feel confident?		
Do you believe stress is currently reducing your quality of life?		
Do you feel your life has meaning and purpose?		
Do you like the work you do?		
Do you spend the majority of your time and money to fulfill responsibilities and obligations?		
Do you find it difficult to trust others?		
Do you often feel overwhelmed by life?		
Do you practice meditation or relaxation techniques?		
Have you ever been abused or experienced a significant trauma?		

Do any events/moments in your life stand out as being more stressful?
If yes, describe:

What do you worry about most in your life?

What do you do to relieve stress and relax?

Have you tried any relaxation techniques? Choose all that apply					
	Yoga		Meditation		Tai Chi
	Deep breathing		Imagery		Prayer

Dietary Profile

Do you have any food allergies? Please circle * Yes / No

If yes, please list the foods:

Do you have any food sensitivities? Please circle * Yes / No

If yes, please list the foods:

Have you been tested for food sensitivities or is the above based on reaction to the food consumed?

Please list foods that you will not eat under any circumstances:

What do you eat and use? How often?

Please indicate next to the selection "1" for rarely, "2" for regularly,"3" for often *

	Aluminum pans		Margarine		Fried foods
	Microwave		Candy/chocolate/sugar		Packaged foods
	Luncheon meats		Splenda/Aspartame		Fast foods

How many cups of the following do you drink per day?

	Bottled Water		Red Wine		Filtered Water
	Tap Water		Fresh Fruit Juice		Alcohol
	Reduced Fat Milk		Soy Milk		Non-Diet Soft Drinks
	Diet Soft Drinks		Vegetable Juice (fresh)		Full Fat Milk

How many ½ cup servings of each do you typically eat in a day?

Fruit

Vegetables

Whole Grains

Protein

Dairy

What are your favorite foods?

Do you experience any symptoms if meals are missed?

Please explain *

Do you experience any symptoms after meals? (ie bloating, gas, fatigue etc)

Please explain *

Are there foods you avoid because of how they make you feel?
Include the food & symptoms *

Do you currently follow a special diet or nutritional program?

Choose all that apply:

	Low-fat		Low-Carb		High-Protein
	Low-sodium		Dairy-free		Diabetic
	Gluten-free		Vegetarian		Vegan

Do you grocery shop? Yes No

If no, who does the shopping?

If you could only eat a few foods a week, what would they be?

Do you cook? Yes No

If no, who does the cooking?

Do you read food labels? Yes No

Do you count calories? Yes No

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week H**ave you made any changes in your eating habits because of your health?** Yes No

If yes, explain:

Dental Profile

Choose all that apply:

	Mercury fillings		Tooth pain		Gingivitis
	Root canals		Bleeding gums		Composite fillings
	Ulcers/lesions		Problems chewing		Floss regularly

Supplements & Medications

List vitamins/supplements/enhancers/herbs are you currently taking, including brand name if possible:

Type & Brand	Dosage	Frequency	Reason for Use	Start Date

List prescription medications you are currently taking or have taken in the last 5 years:

Medication	Dosage	Frequency	Reason for Use	Start/End Date

Do your medications or supplements ever cause unusual side effects or problems?

Yes No

If yes, indicate which supplement or medication and describe side effects:

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.)? Yes No **Have you had prolonged or regular use of Tylenol?** Yes No

Have you had prolonged or regular use of Acid Blocking Drugs (Zantac, Prilosec, etc.)? Yes No

Antibiotics use more than 3 times/year? Yes No

Long term antibiotics at any time during your life? Yes No

Use of steroids (prednisone, nasal allergy inhalers) in the past? Yes No

Do you use recreational drugs? Yes No

If yes, how often and what type (all answers are confidential) *

Do you use Marijuana or CBD therapeutically? Yes No

If yes, what forms and how often (edibles, oils, etc):

If you use CBD please indicate the dosage, frequency, and what you use it for:

Do you smoke? Yes No

How many years? Packs per day:

Previous smoking: How many years? Packs per day:

Second hand smoke exposure?

Symptomatology Assessment

Please indicate frequency of issue or symptoms:

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 1: Adrenal Health	0	1	2	3	Notes:
Fatigue in the afternoon					
Trouble staying asleep					
Cravings for salty food					
Dizziness when standing quickly					
Slow start in mornings					
Eyes sensitive to bright light					
Grinding teeth					
Difficulty falling asleep					
Hives					
Perspire often with no activity					
Wake up tired even after enough sleep					
Weak nails					
Afternoon headaches					
Trouble recovering from stress					
Headache with exertion or exercise					
Under a high amount of stress					

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Section 2: Vitamin/Mineral	0	1	2	3	Notes:
Loss of muscle tone					

Small bumps on back of arms					
Racing heart					
Numbness or tingling					
Feeling depressed					
Gums bleed easily					
Body jerks when falling asleep					
Persistent worry or anxiety					
Bruise easily					
Nosebleeds					

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Section 3: Colon Health	**0**	**1**	**2**	**3**	**Notes:**
Feeling bowels do not empty completely					
Diarrhea					
IBS or colitis					
History of parasites					
Yeast infections					
Itchy anus					
Parasites					
Nail fungus					
“Fuzzy” tongue					
Loose stools					
Lack of daily bowel movements					
Abdominal cramping					
Use laxatives					
Pass bad smelling gas					

Abdominal pain relieved by passing gas or having a bowel movement					
Blood in stool					
More than 3 bowel movements per day					
Alternating diarrhea and constipation					
Hemorrhoids					
Celiac disease					
Bloating after consuming grains					
Belching					
Heartburn					
Nausea or Vomiting					
Diverticulitis					

Bowel movement frequency:		**Bowel Color:**		**Bowel consistency:**	
	Lots of toilet paper needed		Very Dark or Black		Soft & Well Formed
	Skinny stool		Yellow, Light Brown		Hard & Painful
	Floating		Greasy/Shiny		Watery & Loose

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 4: Thyroid Health	**0**	**1**	**2**	**3**	**Notes:**
Night sweats					
Flush easily					
Difficulty gaining weight					
Easily fatigued					
Cold hands and feet					
Low body temperature					
Sensitivity to cold					

Intolerant to heat					
Heart palpitations					
Insomnia					
Fast resting pulse					
Thinning hair or hair loss					
Thinning of lateral 1/3 of eyebrows					
Morning headaches that go away					
Stubborn easy weight gain					
Lack of motivation or depression					
Nervousness					
Excessively sleeping					
Dry skin					
Puffy face					
Weakness and aches in muscles and joints					

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Section 5: Respiratory Health	**0**	**1**	**2**	**3**	**Notes:**
Asthma					
Chronic sinusitis					
Exercise induced asthma					
Sleep apnea					
Pneumonia					
Emphysema					
Bronchitis					

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 6: Liver & Gallbladder Health	**0**	**1**	**2**	**3**	**Notes:**

Insomnia					
Stomach gets upset after eating greasy or high-fat foods					
Metallic taste in mouth in the morning					
Eyes are yellow					
Excessive hair loss					
Sensitivity to perfume					
Sensitivity to chemicals					
Easily intoxicated after a small amount of alcohol					
Pain under rib cage on right side					
Fish-tasting burps after taking fish oil					
Palms of hands look red					
Gallstones or gallbladder attack					
Weight gain					
Nausea					
Motion sickness					
Gas and bloating for hours after eating					
Unexplained swelling in legs and ankles					
Pain between shoulder blades					
Headache over eyes					
Stool color looks like grey clay					
Hemorrhoids					
Alcohol abuse					
Itchy and/or peeling feet					
Chronic fatigue					

Dark coloured urine					

Do you have any of the following conditions? Check the selection(s) that apply					
	Hepatitis		Wilson's Disease		Gallstones
	Cirrhosis		AIDS		Non-alcoholic Fatty liver disease

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Section 7: Endocrine & Blood Sugar Health	**0**	**1**	**2**	**3**	**Notes:**
Crave sweets, alcohol or coffee					
Difficulty losing weight					
Need sweets after a meal					
Waist girth is equal to or larger than hip girth					
Increased thirst					
Frequent urination					
Rely on coffee or sugar to get going and stay going					
Eating relieves fatigue					
Crave sugar after eating it					
Blurred vision					
Difficulty with memory					
Feeling foggy headed					
Feel shaky when hungry					
Easily agitated or nervous					
Get light headed if a meal is late or missed					
Get a headache if a meal is late or missed					

Sudden weakness or shakiness					
Night hunger					
Experience hunger after eating					
Sleepy in the afternoon					
Binge or uncontrolled eating					
Wake up a few hours after falling asleep & have trouble getting back to sleep					

Do you have any of the following conditions? Check the selection(s) that apply					
	Hypothyroidism		Hypoglycemia		Type 1 diabetes
	Hyperthyroidism (Graves)		Metabolic syndrome		Type 2 diabetes
	Addison's Disease		Chronic Fatigue Syndrome		Cushing's Syndrome

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Section 8: Neurological Health	**0**	**1**	**2**	**3**	**Notes:**
Concentration or memory problems					
Migraines					
Irritability					
Depression					
Anxiety / panic attacks					
Worry					
Mood swings					
Vivid dreams					
Attention problems					
Nightmares					

Do you have any of the following conditions? Check the selection(s) that apply

	ADD/ADHD		Bipolar disorder		Anxiety disorder
	Clinical depression		Schizophrenia		Traumatic Brain Injury

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Section 9: Stomach Health	**0**	**1**	**2**	**3**	**Notes:**
Diarrhea after meals					
Fingernails that break easily					
Strong body odour					
Undigested food in stool					
Heartburn or acid reflux					
Gas, burping or bloating after meals					
Bad breath					
Feeling hungry after eating a meal					
Feel better when not eating					
Feeling overfull after meals					
Heartburn after spicy food, chocolate or caffeine					
Digestive problems improve after rest					
Antacids bring relief to digestive issues					
Stomach pain or burning after meals					

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 10: Digestive Reactions	**0**	**1**	**2**	**3**	**Notes:**
Increased pulse after eating					
Sinus congestion					
Alternating constipation and diarrhea					
Bloating after eating starches					
Hives or welts after eating					

Excess gas after meals					
Feeling full for hours after eating					
Allergies					
Gluten sensitivity					
Feeling overfull after meals					
Cravings for bread and pasta					
Increasing food reactions					
Frequent urination					
Feel zoned out after eating					
Constipation after eating fiber					
Aches, pains and swelling					
Yeast infection					
Dark circles under eyes					
Nail fungus					

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 11: Immune Health	**0**	**1**	**2**	**3**	**Notes:**
Runny nose or nasal drip					
Swollen lymph nodes					
Cold and flu					
Shingles					
Cold sores					
Herpes					
Poor wound healing					
Dry/irritated or itchy eyes					
Mucus in throat					
Sinus or ear infections					

Do you have any of the following autoimmune conditions? Check the selection(s) that apply					
	Lupus		Sjogren's syndrome		Raynaud's
	Rheumatoid arthritis		Multiple sclerosis		Inflammatory Bowel Disease
	Vasculitis		Psoriasis		Hashimoto's

Pre-Menopausal Women Only:

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 12: Menstruation Health	**0**	**1**	**2**	**3**	**Notes:**
Perimenopausal					
Night sweats and/or hot flashes					
Vaginal itchiness					
Fibrocystic breasts					
Uterine fibroids					
Facial hair growth					
Length of cycle varies each month					
Cycle is less than 24 days					
Light blood flow during cycle					
Heavy blood flow during cycle					
Irritable and/or depressed					
Acne that does not clear up					
Hair loss					
Yeast infections					
Breast pain and swelling during cycle					
Decreased libido					
Mood swings					
Loss of control of urine					

Palpitations					

Do any of the following apply to you? Check the selection(s) that apply					
	On birth control pill		Breast implants		Have/had breast cancer
	Have an IUD		Taking HRT		Are pregnant or nursing
	Endometriosis		Post partum depression		Hysterectomy

Menopausal/Post Menopausal Women Only:

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 13: Menstruation Health	**0**	**1**	**2**	**3**	**Notes:**
Mental fogginess					
Decreased interest in sex					
Mood swings					
Depression					
Acne					
Facial hair growth					
Vaginal pain, itching, dryness					
Shrinking breasts					
Hot flashes					
Painful intercourse					
How many years have you been menopausal?					

Men Only:

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 14: Male Health	**0**	**1**	**2**	**3**	**Notes:**
Depression					
Uncontrollable sweating					

Difficulty maintaining erection					
Difficulty concentrating					
Muscle soreness					
Pain or burning when urinating					
Difficulty or dribbling when urinating					
Decreased physical stamina					
Decreased libido					
Sinus or ear infections					
Feeling of incomplete bowel emptying					
Have you had a prostate-specific antigen (PSA) test done?					

Health & Medical Conditions

Do you have any other medical condition that has not been addressed above? Please list *

Client Statement

I, _____ agree to allow _____, to design a program for me to enhance my health. I understand that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment, or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This program does not replace the expert advice or medical treatment of my own doctor. I have given _____ all necessary information about myself to prevent any possible complications.

Signature: ______________________________________ **Date:** __________________