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:

Phone:

Email:

Address:

Personal Profile Information

Gender: ( ) Male ( ) Female

Birth date: _____/_____/_____ Age: _____ Height: _____ / _____

Weight NOW: _____ Goal Weight: _____ Body fat % _____

Weekly Exercise Information

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:

Lifestyle / Professional Activity

How would you rate the activity level of your profession, or what you do during the day (non-exercise related). Please circle one ☛

Sedentary Moderately Active Active Very Active

Do you have any hobbies? 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.

What do you feel is your best accountability gauge for your desired progress:

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?

Daily Habits

What time do you normally wake up?

What time do you normally go to bed at night?

How long does it take you to fall asleep?

If you smoke, how many per day?

If you smoke, how many years have you smoked?

Family, Trauma & Lifestyle Profile

Do you have children?

What are their ages ☛

Occupation:

Have you lived or traveled outside North America? If so, when?

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

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

Have you experienced any significant trauma in your life?
Please explain ☛

How much time have you taken off work/school in the last year?

Health Concerns

What are your health concerns? (describe with symptoms and duration)

How have you dealt with these 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)

List any surgical procedures you have had and when they occurred:

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.

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?

Food preferences:

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

Do you eat or use, and 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	Fresh Vegetable
Tap Water	Fresh Fruit Juice	Alcohol
Milk (1% or 2%)	Soy Milk	Soft Drinks
Diet Drinks	Vegetable Juice (fresh)	Milk

Do you feel there are restrictions on your diet due to the preferences of others – family, roommates, etc? Yes No

If yes, please explain ☛

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

Fruit Fresh Dried Canned

Vegetables Cooked Raw

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 have any known allergies or sensitivities? Yes No

Please list the foods here ☛

Supplements & Medications

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

List medications you are currently taking:

Do you use recreational drugs? Yes No

If yes, how often and what type (therapeutic marijuana included) ☛

Health & Medical Conditions

Check any that apply or describe any other(s)

( ) Heart Disease	( ) Hypoglycemia	( ) Allergies
( ) Liver Disease	( ) Diabetes	( ) Hypertension
( ) Celiac	( ) Anemia	( ) Asthma
( ) Kidney Disease	( ) Autoimmune Disease	( ) Pain/Inflammation

Other Conditions:

Please list ☛

Females Only

Are you or could you be pregnant? Yes No

Are you breastfeeding? Yes No

Are you in perimenopausal or menopausal? Yes No

If yes, what are your symptoms?
Please explain ☛

Have you had a bone density test? Yes No
If yes, what was the result ☛

Headaches & Dizziness

◯ Fainting	◯ Migraine	◯ High Blood Pressure
◯ Neck Stiffness	◯ Chronic Headache	◯ Low Blood Pressure

Mouth Health

Check the selection that is chronic (ie you experience frequently) ☛

◯ Bleeding Gums	◯ Bitter Taste in Mouth	◯ Canker Sores
◯ Grind Teeth	◯ Cold Sores	◯ Root Canals

Skin & Hair

◯ Eczema/Psoriasis	◯ Acne	◯ Hair Falling Out
◯ Bruise Easily	◯ Dry Flaky Skin	◯ Hives
◯ Itching	◯ Rash	◯ Changes in Moles

Respiratory & Throat

◯ Chronic Cough	◯ Recurring Sore Throat	◯ Frequent Colds
◯ Nose Bleeds	◯ Sinus Infections	◯ Winded Easily
◯ Chronic Mucus	◯ Shortness of Breath	◯ Phlegm

Emotions & Memory

( ) Relaxed/Calm	( ) Foggy Brain	( ) Depressed
( ) Poor Long-term Memory	( ) Poor Concentration	( ) Anxious/Panic Attacks
( ) Poor Short-term Memory	( ) Easily angered or frustrated	( ) Irritable

Gut Health

Bowel movement frequency:	**Bowel Color:**	**Bowel consistency:**
( ) Not Daily	( ) Very Dark or Black	( ) Soft & Well Formed
( ) 1-3 x per day	( ) Yellow, Light Brown	( ) Hard & Painful
( ) more than 3 x per day	( ) Greasy/Shiny	( ) Watery & Loose

Do you experience frequent gas & bloating?

Please explain (ie after meals, all the time, etc) ☛

Other

Do odors bother you?

Have you had periods of binge eating or severe sugar cravings?

How do you deal with stress? (ie medication, meditation, yoga, supplements, nature walks etc)

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:** _____