Holistic Care Intake Form

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHOURIZED US IN WRITING TO DO SO. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

BASIC INFORMATION

Full Name: ____ Date: __________________

Date of birth __________________________ Age _________ Gender: Male Female

Full Mailing Address:

____

Telephone number:

(home):___________________________(work):________________________________

(mobile): ________________________ Email: __________________________________

May we leave you phone messages in regards to your appointments or orders? Y / N

May we e-mail you upcoming events and specials? Y / N

Marital status_________________ Occupation/ Nature of work:

____

Emergency contact: Name:

Phone number:____________________________Relation:________________________

Who may we thank for referring you to our clinic:

CURRENT/PASTMEDICATIONS

List all current prescription medications and supplements:

Drug/supplement (Name & What it is for): Dosage: Length of time taken:

Drug/supplement (Name & What it is for)	Dosage	Length of time taken

Which of the following have you used? Include when and frequency of use.

☐ Antibiotics	☐ Antacids
☐ Hormones	☐ Sedatives
☐ Steroids	☐ Narcotics
☐ Cortisone	☐ Laxatives

☐ Tylenol	☐ NSAID’s
Specify any other over the counter drugs:	

CHRONOLOGICAL HEALTH HISTORY

This sort of health history helps to establish trends in a person’s health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, and any emotional traumas such as deaths, loss of jobs, divorces, etc.

Are there any conditions of family members you would like to note? You may want to consider family history such as addictions, auto-immune disorders and other major mental or physical conditions that may have contributed in some way to your state of health.

Height (feet/inches)____________________________

Current Weight______________________________

Usual weight range +/- 5 lbs_____________________

Desired Weight range +/- 5 lbs_________________

Highest adult weight ____________________________

Lowest adult weight ____________________________

- ❑ Weight fluctuations (>10lbs) How often do you weigh yourself:_____

- Have you ever been noticeably malnourished? Yes or No
- Have you ever struggled with eating disorders? If so please list when it started and how long:

- How often do you get the common cold? _________ How long does it last?

- Does it tend to settle anywhere in particular (head/neck, chest/lungs, sinuses, etc.)?___________
- How would you rate your health on a scale of 1-5 (5 being excellent):

- Do you take full responsibility for your health? YES NO Somewhat
- Blood type:________
- Date of last physical exam: For what reason?_________________________
- Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc.) Y/N
- Do you use alternative practitioners?
- Have you ever been anemic? YES or NO
- Do you have any of the following:

- ☐ Amalgam fillings (silver)
- ☐ Root canal
- ☐ Periodontal disease
- ☐ Other dental work:

PERSONAL HEALTH HABITS

Are there any foods that you avoid because they give you symptoms? YES or NO

If yes, please name the food and symptom e.g. wheat – gas and bloating: -

____

____

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

____

How many meals do you eat out per week? 0-1_____ 1-3____ 3-5____ >5_____

Check all the factors that apply to your current lifestyle and eating habits:

- ❑ Fast eater
- ❑ Erratic eating habits
- ❑ Eat too much
- ❑ Late night eater
- ❑ Time constraints
- ❑ Eat more than 50% of meals away from home
- ❑ Travel frequently
- ❑ Eat because I have to
- ❑ Have a negative relationship to food
- ❑ Struggle with eating issues
- ❑ Emotional eater (eat when sad, lonely, depressed, bored)
- ❑ Eat too much under stress
- ❑ Eat too little under stress
- ❑ Don't care to cook

- ❑ Non-availability of healthy foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Eating in the middle of the night
- ❑ Confused about nutritional advise
- ❑ Diet often for weight control

CHECK ANY THAT APPLY

- ❑ Skip meals (please specify reason): ________________________________ _____
- ❑ Lack of appetite
- ❑ Excessive appetite
- ❑ Feel hungry shortly after eating a good-sized meal
- ❑ Nausea after meals
- ❑ Specific foods upset, specify: ________________________________ _____
- ❑ Sense of fullness with very little food, or delayed 2-4 hrs. after meal (please underline with one)
- ❑ Digestive problems that subside with rest and relaxation
- ❑ Swallowing difficulty or frequent choking
- ❑ Burning sensation in the lower portion of chest, especially when lying or bending down
- ❑ Burning or aching relieved by eating
- ❑ Stomach pains or burning 1-4 hrs. after meals
- ❑ Three or more bowl movements in a day
- ❑ Less than one bowl movement
- ❑ Undigested food is stools
- ❑ Pass mucus in stools
- ❑ Small, hard, or dry stools
- ❑ Bowl movement shortly after eating (within one hr.)
- ❑ Burping, bloating or gas after eating
- ❑ Lightly colored stools
- ❑ Loose stools
- ❑ Constipation
- ❑ Unexplained itchy skin, especially at night
- ❑ Easily chill, especially after eating, dizzy when rising, and/or darkness under eyes
- ❑ Consistency or form of stools (e.g., from narrow to loose) changes with in the course of the day

# of bowel movements ___________. Are they well-formed, if not specify:
____

FOOD CONSUMTION

What snacks do you eat or drink:

Breakfast & Lunch:
____

Lunch & Dinner:
____

After Dinner:
____

- ❑ **Water:** Glasses/day___ **Type**: Tap:___ Distilled:___ Spring:___ Well:___ Reverse Osmosis:___

Do you smoke? YES NO Amount/day? ________Years smoked?______ Year stopped?___________ Are you exposed to smoking at home? YES NO
Are you exposed to smoking at work? YES NO
Alcohol use? YES NO
Type:____________Frequency:___________
Recreational drug use? YES NO
Type:___________Frequency:____________

LIFESTYLE

1. Are you frequently exposed to animals? YES NO What type? ___________________________
2. Are you regularly exposed to toxins or other hazards? YES NO What kind? ____________________
3. Do you exercise regularly? YES NO Type:________________ Frequency of exercise :__________
4. How many hours do you sleep per night? _________ Do you wake rested: YES NO
5. How many sleep disturbances? _____ How many hours do you work each day? ____ Do you do shift work? Y/N
6. What level of personal stress are you experiencing right now?
   ☐Minimal ☐Average ☐Considerable ☐Unbearable

The main stressor is:
☐Financial ☐Job related ☐Marriage ☐Health
☐Interpersonal ☐Unfulfilled expectations ☐Family ☐Spiritual

What do you do to deal with stress?____
____
____
____

Please complete the Symptoms Survey by following the instructions on the website below. Please save your Login information as we will use this SS again to track your progress. This is a secure website to create a log in and begin your SS:
https://nutriweb.info/HeatherB/