Intake Questionnaire

Personal Information

Legal first name

Last name

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Have you ever taken antibiotics? ◯ Yes ◯ No

Have you ever taken birth control? ◯ Yes ◯ No

Have you ever been on hormone replacement therapy? ◯ Yes ◯ No

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications
List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

List your current health concerns in order of importance

Health Concerns

Do you experience digestive difficulties?
(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement? ◯ Yes ◯ No

Are your bowels loose? ◯ Yes ◯ No

Do you take laxatives? ◯ Yes ◯ No

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Diet

How much water do you drink daily?

Do you consume coffee? ◯ Yes ◯ No

Do you consume tea? ◯ Yes ◯ No

Do you consume alcohol? ◯ Yes ◯ No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you usually eat per day?

How many servings of fruit do you eat per day?

What are your favorite foods?

What foods do you avoid or hate?

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? You wake frequently during the night?

Do you wake feeling rested? ◯ Yes ◯ No

How often do you exercise?

What types of exercise do you do?

What do you do to have fun?

Do you have any pets? ◯ Yes ◯ No

List your main stressors right now.

How many hours per day do you use a computer?

How many hours per day do you watch TV?

Chemicals

Where did you grow up?
City or country?

◯ City ◯ Country

Have you had any recent dental work done?
Do you have fillings (metal), root canals, crowns, etc?

Have you ever had shots/vaccinations?
List all that apply (including flu shots)

What is your level of commitment to improving your health?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

1 = Lowest, 10 = Highest