Health Evaluation Intake Form

Name: _____ Referred by: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (day) _____ (night) _____ (cell) _____

Height: _____ Weight: _____ Body Frame: _____ Blood type: ____ Birthdate: _____

Family/Living Situation: _____ Children: _____

Occupation: _____ Exercise/Recreation: _____

Health Concerns:

What are your health concerns? Describe problems in detail: _____

_____

_____

_____

_____

_____

_____

How have you dealt with these concerns in the past (doctors, self-care)? _____

_____

_____

_____

_____

_____

What other health practitioners are you currently seeing (name, specialty, phone #)? _____

_____

_____

_____

List any medicine or supplements you are currently taking for these problems: _____

_____

_____

_____

Health Evaluation Intake Form—CONTINUED

Have any other family members had similar problems (describe)? _____

_____

_____

_____

Health Hazards:

Does stress make your condition worse? _____

_____

_____

_____

Have you been exposed to or are you sensitive to chemicals? Toxicity: (exposures and sensitivities to chemicals: Tap water, air pollution, job and home exposures, cosmetics, food and chemical residues, *Nutrasweet®*, and medicines including aspirin, birth control, etc.): _____

_____

_____

_____

Do you have or have you had trauma — physical or emotional wounds or abuse? What re-stimulates it? How does it affect your diet and health habits? _____

_____

_____

Have you had periods of eating junk food, binge eating, or dieting? _____

_____

_____

_____

Have you used or abused alcohol, drugs, meds, tobacco, or caffeine? Do you still?_____

_____

_____

_____

Health Evaluation Intake Form—CONTINUED

Do you think any of the above Health Hazards are related to your health issues? _____

_____

_____

_____

Dietary Habits and Choices:

What were your diet and family eating habits like growing up? _____

_____

_____

_____

Describe your diet at the onset of your health problems: _____

_____

_____

_____

_____

_____

Have you used special diets to address your health issues? _____

_____

Describe the foods you eat (comfort foods) when you are:

1. Hungry: _____
2. Angry: _____
3. Lonely: _____
4. Tired: _____
5. Depressed: _____
6. Celebrating: _____

Health Evaluation Intake Form—CONTINUED

How are your mood and energy level affected by eating these foods (nourished or numbing)?

_____

_____

How is your sleep? Can you get to sleep easily? Can you stay asleep? _____

_____

_____

For women: How are/were your cycles? Do/did you have PMS? Painful periods? _____

_____

_____

How are your moods in general? Do you experience more than you would like of anxiety?

Depression? Anger? _____

_____

_____

On a scale of 1-10 — 1 being the worst and 10 being the best — describe your usual level of energy.

(circle one): 1 2 3 4 5 6 7 8 9 10