



## Client Intake Form

### Client Information

Name Date  
Birthday Age  
Address  
Email  
Phone number  
Occupation  
Emergency Contact Name and Number

### Health and Wellness Goals

What brings you to the session today?

What are your health and wellness goals/concerns?

What would you like to accomplish regarding your health and wellness?

Have you previously utilized nutritional and lifestyle protocols for the betterment of your health and wellness, and if so what were they and what were your results?

Are there any obstacles or challenges that you believe may make it difficult to achieve your health and wellness goals?

### Family History (Indicate current or past family conditions or illnesses)

Mother:

Father:

Maternal Grandparents:



Cont ...

Paternal Grandparents:

Siblings:

### **Women's Health**

Do you have regular periods? Yes or No

List any PMS symptoms:

Are you taking birth control? Yes or No

For how long?

Have you had menopause? Yes or No

When?

### **Men's Health**

Do you have erectile concerns?

Do you have prostate concerns?

### **Medications and Prescriptions**

Are you currently being treated for a medical condition?

List any medications you are taking for the condition:

List any other medications you are taking:

List any supplements you are currently taking (including vitamins, mineral, probiotics etc.)



Cont ...

Allergies and Sensitivities (food, drug, seasonal, chemical, other)

When did you last take oral antibiotics? For what?

Dental history:

### **Food Habits**

Are you currently following a specific diet? Yes or No

Vegan Vegetarian Gluten-Free Dairy-Free Paleo Keto Other

Explain:

Do you typically eat breakfast? Yes or No

How many meals do you eat per day?

How often do you eat out at restaurants?

How often do you eat packaged or frozen foods?

Do you drink alcohol? Yes or No How often?

How much?

Do you smoke cigarettes? Yes or No How often?

How many?

What foods do you typically crave?

Sweets Salty Bread/Pasta Caffeine Protein Chocolate Other

How much water do you consume in a day?

What other beverages do you typically consume?

Do you often feel hungry? Yes or No

What 5 foods do you eat most frequently?

- 1.
- 2.
- 3.
- 4.
- 5.



Cont ...

**Indicate all that apply to you current state of being, lifestyle and eating habits**

- Eat too much
- Erratic eating patterns
- Late night eating
- Fast eater
- Often skip meals
- Afternoon fatigue
- Frequent colds/illness
- Do not plan meals/Eat on the run

**Digestion**

How often do you have a bowel movement?

Describe your bowel movements:

- Hard and small
- Loose and watery
- Soft and well formed

Do you suffer from any of the following:

- Gas
- Bloating
- Cramping
- Constipation
- Diarrhea

**Lifestyle**

Describe your typical energy levels:

How often do you exercise?

Type of exercise?

Describe your sleeping patterns (sleep soundly, wake often, difficulty falling asleep etc)



Cont ...

Do you feel rested upon waking?

What is your current stress level?

- Low
- Mid
- High

What do you think is the leading cause of stress for you?

Additional comments/concerns:

How did you hear about us?

### **Informed Consent**

- Nutrition and exercise are intended to promote general health and wellness and are not intended to replace medical care. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input and are not intended to diagnosis, treat or cure any ailment.
- Any activity or program may have inherent risks which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself. You agree to inquire about any activities with which you are not familiar and provide any information which may limit your participation is suggested activities.
- Results and changes with your general health and wellness may vary depending on medical conditions, medications and accuracy in following guidelines.
- Never reduce or eliminate physician prescribed medications without the direction of a medical care provider.

Name:

Signature:

Date: