Client Intake Form

Name:_____Date:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

Email:_____

Occupation:_____

Employer:_____

Date of birth:_____

Marital Status:_____single_____married_____other

Name of Spouse/Significant other:_____

Names and ages of children:_____

Referred by:_____

Current Height:_____

Current Weight:_____

Has there been a medical diagnosis for any particular condition?_____yes_____no

If so, by whom?_____

Please explain:_____

Please list all medications and/or supplements that you are currently using and for what reason:

Present symptoms: What is your major complaint or condition you would like to improve?

What have you done or used to get relief?

Do you exercise regularly?_____yes_____no

Explain:_____

What are your expectations for this visit?

Please list any additional comments or information about your health and wellness:

Please list your TOP 5 favorite foods that you eat regularly:

What do you typically drink for beverages throughout the day?

_____

Do have any food allergies?_____

Do you have any medication allergies?_____

Do you have any seasonal allergies?_____

Do you have any other
allergies?_____

Are you truly ready for a health change?_____yes_____no

Explain:_____

What might hold you back from making changes to lifestyle, nutrition, etc.?

Please check the following conditions that apply to you, past and present.

Musculo-Skeletal:

Headaches_____

Joint stiffness/Swelling_____

Spasms/Cramps_____

Broken/Fractured Bones_____

Strains/Sprains_____

Back, Hip pain_____

Shoulder, Neck, Arm, Hand Pain_____

Leg, Foot Pain_____

Chest, Ribs, Abdominal Pain_____

Problems Walking_____

Jaw Pain/TMJ_____

Tendonitis_____

Bursitis_____

Arthritis_____

Osteoporosis_____

Scoliosis_____

Bone or Joint Disease:_____

Other:_____

Circulatory and Respiratory:

Dizziness_____

Low Blood Pressure_____ High blood pressure_____

Asthma_____

Shortness of breath_____

Fainting_____

Cold feet or hands:_____

Cold sweats:_____

Swollen Ankles:_____

Pressure Sores:_____

Varicose Veins:_____

Blood Clots:_____

Stroke_____

Heart Condition_____

Allergies_____

Please check all that apply to you past and present.

Skin:

Rashes_____

Allergies_____

Athlete's Foot_____

Warts_____

Moles_____

Acne_____

Cosmetic Surgery_____

Other:_____

Digestive:

Nervous Stomach_____

Indigestion_____

Constipation_____

Intestinal Gas /Bloating_____

Diarrhea_____

Diverticulitis_____

Irritable Bowel Syndrome_____

Crohn"s Disease_____

Colitis_____

Nervous System:

Numbness/Tingling_____

Twitching of face_____

Fatigue_____

Chronic Pain_____

Sleep Disorders_____

Ulcers_____

Paralysis_____

Herpes/Shingles_____

Cerebral Palsy_____

Epilepsy_____

Chronic Fatigue Syndrome_____

Multiple Sclerosis

Muscular Dystrophy_____

Parkinson's Disease_____

Spinal Cord Injury_____

Reproductive System:

Pregnancies_____How many?_____

Miscarriages_____How many?_____

PMS_____

Menopause_____

Pelvic Inflammatory Disease_____

Endometriosis_____

Hysterectomy_____

Fertility Concerns_____

Prostrate problems_____

Other:

Loss of appetitie_____

Forgetfulness_____

Confusion_____

Depression_____

Difficulty concentrating_____

Drug use_____

Alcohol use_____

Nicotine use_____

Caffeine use_____

Hearing impaired_____

Visually impaired_____

Burning upon urination_____

Bladder infection_____

Eating disorder_____

Diabetes_____

Fibromyalgia_____

Cancer_____

Infectious Disease_____Please list_____

Other congenital or acquired disabilities_____

Sugeries_____

Other:_____

Symptom List: -Please circle all that may apply to you.

Acne
ADD/ADHD
Adrenal glands
Allergies
Alzheimer's
Anemia
Anger
Anxiety
Appetite
Arteriosclerosis
Arthritis
Asthma
Back pain
Bad breath
Bed wetting
Bell's Palsy
Bites
Bladder
Blood pressure high
Blood pressure low
Boils
Breathing issues
Digestion
Dizzy Spells
Ear infection
Ear ringing
Edema
Emphysema
Epilepsy
Eyesight
Fatigue
Fever
Flu
Gallstones
Gangrene
Gas
Gout
Gums
Hair issues
Heartburn
Hemorrhoids
Herpes
Hiatal hernia
Hives
Parasites
Parkinson's Disease
Perspiration
PMS
Pneumonia
Polyps
Pregnancy
Prostrate
Psoriasis
Rash
Seizures
Shingles
Skin issues
Snoring
Stress
Stroke
Sty
Tumors
Ulcers
Urinary infections
Varicose veins
Vertigo

Bronchitis
Bruises
Burns
Cancer
Candida
Canker sores
Carpal Tunnel
Cataracts
Chest congestion
Chest pain
Cholesterol
Circulation
Cold/flu
Colic
Colon
Constipation
Cough
Cravings
Dandruff
Depression
Diabetes
Diarrhea
Hyperactive
Hyperthyroidism
Hypoglycemia
Impotence
Incontinence
Indigestion
Insomnia
Joint pain
Kidney stones
Laryngitis
Leprosy
Leukemia
Liver
Lung issues
Lupus
Menopause
Menstrual cramps
Migraines
Mononucleosis
Nausea
Nervousness
Nose bleeds
Weight-underweight
Weight-overweight
Yeast infections

OTHER:_____

General Questionnaire for Thyroid Function

Please check all that apply to you:

Depression_____(5)

Weight Gain_____(8)

Difficulty losing weight_____(10)

Low energy/fatigue_____(6)

Cold natured_____(8)

Ice cold hands or feet_____(10)

Dry skin_____(6)

Hair loss_____(8)

Slowed thinking, poor concentration_____(8)

Brain fog_____(10)

Memory problems_____(4)

Insomnia, poor sleep_____(3)

Waking up exhausted_____(5)

Tingling in hands and feet_____(2)

Muscle pain_____(2)

Edema (swelling in ankles)_____(2)

Constipation_____(1)

Slow heart rate_____(5)

Low blood pressure_____(4)

Elevated cholesterol_____(8)

Thickened tongue_____(6)

Muscle cramps at night_____(10)

Slow reflexes_____(4)

Your skin itches in the winter_____(4)

Recurrent headaches_____(3)

Decreased sweating_____(2)

Multiple miscarriages and infertility_____(9)

Pale/pasty colored skin_____(2)

Decreased body hair_____(4)

Vertigo_____(4)

Hoarse voice_____(1)

Fibrocystic breasts_____(10)

Low body temperature below 98.6_____(10)

Anemia_____(2)

Thinned eyebrows_____(8)

Client Authorization Form

Date_____

Name of client_____

Carefully read the following and initial.

~I acknowledge that the Nutritional Profile, Evaluation, Suggested Nutritional Program and any Supplemental materials such as vitamins, minerals, enzymes and herbs are not for the diagnosis, treatment, cure, alleviation, prevention or care of any disease of any kind. I agree that I _____(your full name) am completely responsible for obtaining qualified medical assistance for any such services for the care of any disease or pathological condition. I reserve the right to use the knowledge I gain from this consultation in any legal manner I may choose in the care of my own body. I further declare that the sole reason for requesting the services from this office is for obtaining a suggested natural nutritional program for the building of my health and well-being. _____initials

~I completely understand that consultations are limited to education in matters pertaining to the improvement in the overall health and physical fitness for maintenance of the best possible state of physical, mental and emotional health. These subjects may or may not include the examination of urine and saliva. Such procedures are not for the diagnosis or treatment of any health condition or disease. _____initials

~I acknowledge that I am free to obtain a second opinion from another practitioner at any time I feel it is necessary._____initials

~I understand that all I say during my consultation and information concerning myself can be released to another alternative health practitioner only with my signed consent._____initials

~I acknowledge that I _____(your full name)

am not a representative of a branch of a municipal, state, U.S. Government, the American Medical Association or the Federal Drug Administration._____initials

~I understand that Melodee Uribe of Essentia Natural Health Consulting is not a medical doctor, does not prescribe, diagnose, treat, cure, prevent or heal any disease or make claims thereof._____initials

~I have fully read and completely understand the above listed information and I do hereby request that I be allowed to participate in a health consultation for the following reasons:

Signature_____Date_____

Accepted by_____Date_____