

## **Client Intake Questionnaire**

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This form is fillable, please complete, save; then email back to me.

		City:			
Postal Code:					
Referred By:	Blood T	ype: A□ B□ AB□ O□			
		_Weight: Height:			
Past experience with other prac	etitioners (i.e. Chiropractor, Naturop	eath, Therapist, Homeopath, Massage)			
1					
Recent Diagnosis:					
		Date:			
Surgeries:					

What physical trauma / accidents have you experienced	1?	
Family Health History (Mother/Father Siblings etc	····	
List any medications you are taking <b>now or have in</b> Medication	the past. <u>Reason</u>	<u>How long</u>
List any supplements you are currently taking.		
Supplements  Supplements	Amount	<u>How long</u>
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Do you consume a	ny of the follow	ving? How mu	ich each day?		
Black Tea ☐ Gree	n Tea □ Coffe	ee 🗆 Herbal T	ea 🗆 Alcohol 🗆	Water $\square$	Fruit Juice  Pop
Sugar/artificial swe	etener   Mill	k □ Cream □	Margarine □ Bu	ıtter 🗆 C	Cheese
Do you smoke now	? In the	e past?	For how long?	When	did you quit?
Allergies, you know	v of?				
What foods do you	crave?				
Exercise: What Kind:					
Frequency:					
How is your co	ncentration/foc	us?			
Bowel movements:	: # per day?				
<b>Type, please expla</b> (i.e. Strained, loose, s		iin, diarrhea, exp	olosive, constipated,	undigested	food, blood or mucus in stool)
What time do you g	go to bed?	What ti	me do you get up?		Fall asleep easily?
Restless sleeper?	Wake up dur	ing the night?	Feel rested wh	nen wakin	g?
Do you snore?	Do you have	sleep apnea?	What position	do you sl	eep in?
Is your weight stabl	e or up/down?				Constantly dieting?
<b>Menstrual Cycle:</b>					
Regular	Cramping	PMS Y	east/Bladder Infect	tions	Last period:
Birth contro	l pills?		Hormone repl	acement?	
Frequent uri	nation P	rostate enlarge	ment		
C	ilver fillings: H	•	Any Remove		10
How many of Crowns or o	& when? other metals (bra		oot Canals?	Teeth	removed?
Crowns or c	diei inetals (of	ices, returners,	partiais).		
Do you have any	y tattoos?	Yes, How Ma	ny?		
		No			
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Previous occupation(s)?				
Do you have a high stress job or stressful relationship/situation?				
What emotional trauma/events have you experienced?				
What do you do to manage / relieve your stress?				
What are your hobbies now and previous?				
Do you use any of the following items? If so, which ones and how much? (use space below)				
Cell phone Cordless phone Computer Microwave Aluminium cookware				
Electric blanket Waterbed Antiperspirant Perfume/hairspray				
pesticides on lawn/flowers/vegetable garden				
Where have you lived?				
How old is your home? Remodeling/construction/new carpets/paint?				
Are there hydro lines or transformers near your home or work?				
What could get in the way of your plan of action?				
Please complete a 3-4-day Daily Food Record on the chart provided.				
This information is provided for a nutritional assessment. I understand that the information I am seeking is of a nutritional nature and <u>not</u> a medical diagnosis.				
Signature: Date:				

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