Client Intake Questionnaire

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Name:	
Address:	City:
Postal Code:	Email:
Home Ph:	Bus/Cell Phone:

Referred By: Blood Type:

Date of Birth Age: Weight: Height:
month / day / year

Occupation(s)

Past Experience with other practitioners (i.e., Chiropractor/Naturopath/Therapist/Homeopath/Massage)

List one to five health goals you would like to attain for yourself, in order of priority:
(How long have these been a concern to you?)

1.
2.
3.
4.
5.

"I haven't felt well since"

What do you believe, or suspect is the reason for your condition?

Recent Diagnosis:

Surgeries: *Include Date(s)*

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Past conditions or other health information you would like us to know with dates. Include Childhood Illnesses. Please use separate sheet or record on back of this sheet.

List any vaccinations that you have had including flu shots: *Dates Received*

What physical trauma/accidents have you experienced?

Family Health History: *Please share any illness that has been experienced in the family you feel important.*

Mother

Father

Siblings

List any medications you are taking **now or have in the past**.

Medication	**Reason**	**How long**

List any supplements you are currently taking.

Supplements	**Amount**	**How long**

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Do you consume any of the following? How much each day? Please be specific! (Eg. Coffee 3 x's day)

Item	How much each day?	Item	How much each day?
Alcohol		Sugar/artificial sweetener	
Black Tea		Pop/Soda	
Green Tea		Milk	
Herbal Tea		Cream	
Coffee		Margarine	
Water		Butter	
Fruit Juice		Cheese	

Do you smoke: Yes ☐ No☐ Have you in the past? ☐ If so, for how long? _____
When did you quit? _____

List any allergies that you know of.

What foods do you crave?

Exercise:

What Kind	Frequency

How is your concentration/focus?

Bowel movements: # per day? ___ **Type of bowel movements, please check all that apply:**

Strained ☐	Soft ☐	Very thin ☐	Explosive ☐
Loose ☐	Hard ☐	Diarrhea ☐	Constipated ☐
Undigested food ☐	Blood ☐	Mucus ☐	

Sleeping Habits:

What time do you go to bed?	
What time do you get up?	
Fall asleep easily?	
Restless sleeper?	
Wake up during the night?	
Do you feel rested when waking?	
Do you snore?	
Do you have sleep apnea?	
What position do you sleep in?	

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Is your weight stable or up and down?

Are you constantly dieting?

Menstrual Cycle:

Regular☐ Cramping ☐ PMS☐ Yeast/Bladder Infections ☐
Last period_____

Do you or have you taken Birth control pills? If so, for how long?

Hormone replacement? ☐ Yes or ☐No

Frequent urination ☐ (Male) Prostate enlargement ☐

Teeth, if any of the following, please include how many and when.

Amalgam/Silver fillings: How many?	
Any Fillings Removed?	
Root Canals?	
Teeth Removed?	
Crowns or other metals (braces, retainers, partials)?	

Do you have any tattoos? ☐ If Yes, How Many? ____ ☒ No

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?

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Do you use any of the following? *If so, how often?*

Eg. Daily, #of hours of use, please be specific please.

Item	How much each day?	Item	How much each day?
Cell Phone		Hairspray	
Cordless Phone		Pesticides in garden, lawn flowers or veg garden	
Computer		Electric blanket	
Microwave		Aluminium cookware	
Waterbed		Antiperspirant	
Perfume		Paint thinners/chemicals	

Where have you lived?

How old is your home?

Remodelling/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 not a medical diagnosis.

Signature:	**Date:**

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