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Client Intake Form

Section A – Personal Details

Full Name: **Gender:**

Date of Birth: **Age:** **Blood type:**

Address:

Tel: (H) **Cell:** **Email:**

Height: **Weight:** **Weight 1 year ago:**

Occupation:

Relationship status (single, married, separated, divorced)**:**

Children and/or Pets:

Primary Care Physician: **Phone:**

Have you ever seen a nutritionist and/or health coach before? If yes, when?

What is your primary reason for seeking nutritional advice?

Which personal goal/s do you wish to achieve in the next 6 months?

Section B – Health History and Lifestyle practices

Do you currently have any diagnosed medical condition, or do you have a history of any medical issue (incl. any allergies)?

Do you currently experience any pain or discomfort anywhere in your body? *Please be specific*

Are you currently undergoing any conventional cancer treatments, such as chemotherapy, radiation, surgery?

If yes
Name: Frequency / Duration:

If yes, please list any related side effects you are experiencing right now:

Are you currently undergoing any complementary treatments, such as vitamin infusions, biofeedback sessions, psychotherapy, Reiki, massage, cranio-sacral therapy?

If yes
Name: Frequency / Duration:

Are you currently taking any prescription medications?

If yes
Name: Reason: Dosage/day:

Do you regularly (at least once or twice a week) take over the counter medications?
(such as antacids, anti-histamines, anti-inflammatories, pain medications, laxatives, stool softeners) List any:

Are you currently taking any nutritional supplements / herbs / natural or homeopathic remedies?
If yes, please list brand name:

Please list any previous hospitalizations or surgeries.

Do you have a family history of chronic diseases? *(such as cancer, heart disease, diabetes, high blood pressure, rheumatoid arthritis. If yes, which family member was affected?*

How would you rate the state of your current immune system?
Excellent Good Fair Poor

Do you experience any food sensitivities? *(if any - incl. age at time of diagnosis)*

Do you experience any food allergies? *(if any - incl. age at time of diagnosis)*

Are you happy with your current weight?
Yes: No: Why not?

Do you have regular bowel movements? *(at least once/twice a day*)
Yes: No:

Briefly describe the color and texture of your stool. *(e.g. hard/soft, clean/smudgy)*

How many hours of uninterrupted sleep do you generally get per night?

Is this sufficient sleep for you?
Yes: No:

Do you regularly (at least 2/3 times a week) wake up at night?
If yes, why, and how long before you fall asleep again?

Do you smoke?
Yes: No:

Are you exposed to smoke on a regular basis?
Yes: No:

Are you exposed to chemicals at work on a regular basis?
Yes: No:

Do you drink more than 6 alcoholic beverages per week (incl. weekends)?
(1 alcoholic beverage = 1 beer, glass of wine, other liquor)

Yes: No:

List the 3 main stress factors (if any) in your life currently:
(such as emotional or psychological strain or trauma in relation to job and/or career, financial situation, relationships, family, children, friendship, health

How well do you tolerate stressful situations?

What activity/ies do you usually do for personal relaxation?

On average, how many hours / day do you spend outdoors (weather and season permitting)?

How do you generally motivate yourself when facing a challenging task?

Section B-1 Women's Health

Do you have regular menstrual cycles?
Yes: No:

Are you experiencing menopause as a result of cancer treatment?
Yes: No:

If yes, do you experience any related side effects, such as night sweats, hot flushes, etc? Please specifiy

Do you experience any of the following while menstruating? Please answer Y/N

___ Heavy bleeding
___ Migraines (how long?)
___ Severe mood swings
___ Prolonged bleeding (more than 4 days)
___ Severe abdominal pain/cramping (unable to work)

If you are practicing birth control, which type? Please mark with X

___ Contraceptive pill
___ Natural cycle observance
___ Other
___ IUD (copper)
___ Nuvaring
___ IUD (hormone-impregnated)
___ None

Do you regularly experience any of the following issues: Please mark with X

___ Low or loss of libido
___ Yeast infections (candida and thrush)
___ Frequent urinary tract infections
___ Painful intercourse

Section C – Digestive Health

This section deals with your digestive health and serves as a screening tool to help identify specific areas that may require attention. It does not serve as a diagnosis, medical or otherwise, of your health situation, nor is it meant to be a prescription for treatment, or substitute advice given by your medical team or healthcare professional.

Please indicate by using the appropriate number below which of these symptoms applies to you now.
0 = never / rarely
1 = occasionally / mild
2 = often / moderate
3 = nearly always / severe

Section 1 - Hypoacidity of the stomach

	Burping
	Fullness for extended time after meals
	Bloating
	Poor appetite
	Stomach upsets easily
	History of constipation
	Known food allergies
	Iron-deficiency anemia
	Nausea after taking supplements
	TOTAL Priority: 0-4: low, 5-9: moderate, 10 or above: high

Section 2 – Hyperacidity of the stomach

	Stomach / abdominal pains
	Need for antacids for heartburn / acid reflux
	Butterfly sensation in stomach
	Burping or bloating
	Regurgitate undigested food into mouth
	Stomach pain when emotionally upset
	Sudden, acute indigestion
	Relief of symptoms by carbonated drinks
	Relief of stomach pain by drinking milk
	Current, or history or family history of ulcers
	Black stool when not taking iron supplements
	Regular use of pain medications (aspirin, ibuprofen)
	TOTAL Priority: 0-4: low, 5-8: moderate, 9 or above: high

Section 3 – Hypofunction of small intestine / pancreas

	Abdominal cramps
	Indigestion 1 to 3 hours after eating
	Fatigue after eating
	Lower bowel gas
	Alternating constipation and diarrhea
	Diarrhea
	Roughage and fiber cause constipation
	Mucus in stool
	Stool poorly formed
	Shiny stool
	3 or more large bowel movements daily
	Foul smelling stool
	Undigested food in stool
	Pain in left side under rib cage or chronic stomach pain
	Nausea
	Acid reflux / heartburn
	Difficulty gaining weight
	Dry, flaky skin and/or dry, brittle hair
	TOTAL Priority: 0-6: low, 6-10: moderate, 10 or above: high

Section 4 – Liver and Gallbladder

	Intolerance to greasy food
	Headaches after eating
	Light-colored stool
	Foul smelling stool
	Less than 1 bowel movement per day

	Constipation
	Hard stool
	Sour taste in mouth
	Gray-colored skin
	Yellow in whites of eyes
	Bad breath
	Body odor
	Fatigue and sleepiness after eating
	Pain in right side under rib cage
	Pain when passing stool
	Water retention
	Painful big toe
	Pain radiates along outside of leg
	Dry skin or hair
	Red blood in stool No=0 , Current=1, More than 2 years ago=2
	TOTAL Priority: 0-2: low, 3-5: moderate, 6 or above: high

Section 5 – Small Intestinal bacterial overgrowth

	Excessive gas / flatulence
	Abdominal bloating and distension, especially with sugar, fiber or carbohydrates
	Diarrhea
	Abdominal pain
	Irritable bowel syndrome
	Fibromyalgia
	Restless leg syndrome
	Intolerance to probiotic supplements
	Scored 9 or more on Section 1 – Hypoacidity of stomach
	Are taking antacids for heartburn / GERD
	TOTAL Priority: 0-4: low, 5-9: moderate, 10 or above: high

Section 6 – Intestinal permeability / Leaky Gut Syndrome Dysbiosis

	Constipation and/or diarrhea
	Abdominal pain and bloating
	Mucus or blood in stool
	Joint pain or swelling, or arthritis
	Chronic or frequent fatigue
	Food allergy or food sensitivities or intolerance
	Sinus or nasal congestion
	Chronic or frequent inflammations
	Eczema, skin rashes or hives
	Asthma, hay fever or airborne allergies
	Confusion, poor memory or mood swings
	Use of nonsteroidal anti-inflammatory drugs (NSAID's) (Tylenol, Aspiring, Advil, Motrin)
	History of antibiotic use
	Alcohol makes you feel sick
	Headaches or migraine headaches
	Chronic nasal congestion
	TOTAL Priority: 1-5: low, 6-10: mild, 7-19: moderate, 20 or above: high

Section 7 – Colon / Large intestine

	Recurring diarrhea
	Frequent infections (cold)
	Bladder and kidney infections
	Vaginal yeast infection
	Abdominal cramps
	Toe and fingernail fungus
	Alternating diarrhea and constipation
	Constipation
	History of antibiotic use
	Meat eater Never=0, rarely=1, often=2, daily=3
	Rapidly failing vision
	Blood or pus in stool
	Family history of inflammatory bowel disease
	Recurrent stomach pain
	TOTAL Priority: 0-5: low, 6-9: moderate, 10 or above: high