New Client Intake Form

Client Information

Name:_____Address:_____

Email: _____Phone (best contact number): _____Cell/Work/Home

Preferred Communication: Phone/Email Date of Birth: _____ Age: _____ Birth Sex: Male/Female

Identify as: Male/Female/Other _____ Height: _____ Weight: _____

Would you like your weight to be different _____, if so what? _____Ethnicity: _____

Relationship Status:_____Children: _____ Pets:_____

Occupation:_____ Hours of Work per Week: _____ Employer: _____

How did you here about Kris Wellness: _____

Health Objectives

In your opinion, what are your most important physical, emotional and/or mental health goals?

1. _____
2. _____
3. _____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?_____

At what point in your life did you feel your best? _____

Why?_____

What is your vision of health in three months? _____

In six months?_____

In one year? _____

What are some factors that get in the way of your health goals?

1. _____
2. _____
3. _____
4. _____
5. _____

Health History

How would you describe your current state of health? Excellent/Good/Average/Fair/Poor

Where, when and for what did you last seek medical care? _____

Have you had any major medical diagnosis (diabetes, heart disease, cancer, etc)? Please indicate how you are currently being or have been treated? Are you currently seeing a specialist or being managed for these?

1. _____
2. _____
3. _____

Are you currently taking any medications and or supplements?

_____

Do you have any allergies? (medications, substances, seasonal)Please describe your reactions_____

_____

What is your blood type? _____ Any healers, helpers or therapies with which you are involved? Please list:

_____

Current Doctor: _____ Last Blood Test(s) Done and When: _____

Immunizations: _____

Have you taken antibiotics in the past? _____ If so, when was the last time and about how often have you taken them? _____

Are your periods regular? _____ Painful or symptomatic? Please explain: _____

Reached or approaching menopause? _____ Please explain: _____

Birth control history: _____

Do you experience yeast infections or UTIs? _____ Please explain: _____

Check any childhood illnesses that you have had:

Measles ____ Mumps ____ Chicken Pox ____ Whooping Cough ____ Roseola ____ Polio ____ Rheumatic Fever ____

Scarlet Fever ____ Diphtheria ____ Asthma ____ Eczema ____ Frequent ear infections or colds as a child? ____

Previous Surgeries and Hospitalizations: _____

Family Health History: List ages and any major health problems. If deceased, please list age at death and cause.

Mother: _____ Father: _____

Brothers: _____ Sisters: _____

Mother's Family: Grandfather: _____ Grandmother: _____

Father's Family: Grandfather: _____ Grandmother: _____

Medical History

Please check any of the following symptoms or conditions that you have had in the past or are currently experiencing:
Y = yes, currently N = never, P = past

Energy:
Fatigue ❑ Y ❑ N ❑ P

Skin:
Rash ❑ Y ❑ N ❑ P
Eczema ❑ Y ❑ N ❑ P
Itching ❑ Y ❑ N ❑ P
Lumps ❑ Y ❑ N ❑ P
Sun Damage ❑ Y ❑ N ❑ P

Head:
Headaches ❑ Y ❑ N ❑ P
Migraines: ❑ Y ❑ N ❑ P
Head Injury: ❑ Y ❑ N ❑ P

Eyes:
Impaired Vision: ❑ Y ❑ N ❑ P
Eye Pain: ❑ Y ❑ N ❑ P
Tearing: ❑ Y ❑ N ❑ P
Dryness: ❑ Y ❑ N ❑ P
Double Vision: ❑ Y ❑ N ❑ P
Glaucoma: ❑ Y ❑ N ❑ P
Cataracts: ❑ Y ❑ N ❑ P

Ears:
Impaired Hearing: ❑ Y ❑ N ❑ P
Ringing: ❑ Y ❑ N ❑ P
Earaches: ❑ Y ❑ N ❑ P

Nose/Sinuses:
Frequent Colds: ❑ Y ❑ N ❑ P
Stuffiness: ❑ Y ❑ N ❑ P
Sinus Issues: ❑ Y ❑ N ❑ P
Hay Fever: ❑ Y ❑ N ❑ P

Mouth/Throat:
Frequent Soar Throat: ❑ Y ❑ N ❑ P
Gum Issues: ❑ Y ❑ N ❑ P
Hoarseness: ❑ Y ❑ N ❑ P
Dental Cavities: ❑ Y ❑ N ❑ P
Cold Sores: ❑ Y ❑ N ❑ P
Canker Sores: ❑ Y ❑ N ❑ P

Respiratory:
Cough: ❑ Y ❑ N ❑ P
Asthma: ❑ Y ❑ N ❑ P
Bronchitis: ❑ Y ❑ N ❑ P
Pneumonia: ❑ Y ❑ N ❑ P
Emphysema: ❑ Y ❑ N ❑ P
Trouble Breathing: ❑ Y ❑ N ❑ P
Pain Breathing: ❑ Y ❑ N ❑ P
Shortness of Breath: ❑ Y ❑ N ❑ P

Cardiovascular:
Heart Disease: ❑ Y ❑ N ❑ P
Angina: ❑ Y ❑ N ❑ P
Hypertension: ❑ Y ❑ N ❑ P
Murmurs: ❑ Y ❑ N ❑ P
Chest Pain: ❑ Y ❑ N ❑ P
Palpitations: ❑ Y ❑ N ❑ P
Ankle Swelling: ❑ Y ❑ N ❑ P

Urinary:
Pain Urinating: ❑ Y ❑ N ❑ P
Increased Frequency: ❑ Y ❑ N ❑ P
Unable to Hold: ❑ Y ❑ N ❑ P
Frequent Infections: ❑ Y ❑ N ❑ P
Kidney Stones: ❑ Y ❑ N ❑ P

Extremities:
Varicose Veins: ❑ Y ❑ N ❑ P
Thrombophlebitis: ❑ Y ❑ N ❑ P
Nail Fungus: ❑ Y ❑ N ❑ P
Restless Legs: ❑ Y ❑ N ❑ P

Emotional:
Anxiety/Panic: ❑ Y ❑ N ❑ P
Depression: ❑ Y ❑ N ❑ P
Mood Swings: ❑ Y ❑ N ❑ P
Weeping: ❑ Y ❑ N ❑ P
Compulsions: ❑ Y ❑ N ❑ P
Excessive Anger: ❑ Y ❑ N ❑ P
Restless Mind: ❑ Y ❑ N ❑ P

Gastrointestinal:
Gas/Belching: ❑ Y ❑ N ❑ P
Heartburn: ❑ Y ❑ N ❑ P
Indigestion: ❑ Y ❑ N ❑ P
Constipation: ❑ Y ❑ N ❑ P
Diarrhea: ❑ Y ❑ N ❑ P
Hemorrhoids: ❑ Y ❑ N ❑ P
Vomiting: ❑ Y ❑ N ❑ P
Abdominal Cramps: ❑ Y ❑ N ❑ P
Binge Eating: ❑ Y ❑ N ❑ P
Gall Bladder Issues: ❑ Y ❑ N ❑ P
Liver Problems: ❑ Y ❑ N ❑ P

Musculoskeletal:
Joint Pain/Stiffness: ❑ Y ❑ N ❑ P
Arthritis: ❑ Y ❑ N ❑ P
Muscle Cramps: ❑ Y ❑ N ❑ P
Muscle Spasms: ❑ Y ❑ N ❑ P
Weakness: ❑ Y ❑ N ❑ P
Broken Bones: ❑ Y ❑ N ❑ P

Endocrine:
Hypothyroid: ❑ Y ❑ N ❑ P
Hyperthyroid: ❑ Y ❑ N ❑ P
Low Blood Sugar: ❑ Y ❑ N ❑ P
Diabetes: ❑ Y ❑ N ❑ P

Blood:
Anemia: ❑ Y ❑ N ❑ P
Easy Bruising: ❑ Y ❑ N ❑ P
Clotting Disorder: ❑ Y ❑ N ❑ P

Neurological:
Fainting: ❑ Y ❑ N ❑ P
Seizure: ❑ Y ❑ N ❑ P
Paralysis: ❑ Y ❑ N ❑ P
Numbness/Tingling: ❑ Y ❑ N ❑ P
Memory Loss: ❑ Y ❑ N ❑ P

Lifestyle and Personal Habits

Describe your energy level on a scale of 1 to 10 (1= lowest, 10= highest) 1 2 3 4 5 6 7 8 9 10

At what point in the day do you feel your best? _____ your worst? _____

Describe your general level of stress on a scale of 1 to 10 (1= lowest, 10= highest) 1 2 3 4 5 6 7 8 9 10

What are your biggest sources of stress, currently?

1. _____ 2. _____

3. _____ 4. _____

Do you smoke? _____ If so, for how long and how much per day? _____

If no, have you smoked in the past? _____ If so, for how long and how much? _____

Do you drink alcohol? _____ If so, how often? _____ How many drinks per week? _____

Do you use recreational drugs? _____ If so, what types and how often? _____

Do you use any of the following? If so, note how much and for how long:

Antacids _____ Caffeine (soda, coffee)_____Cortisone_____

Laxatives _____ Hormones _____ Sedatives _____

Do you exercise? _____ How often? _____What types of exercise do you do? _____

How much time do you spend each day relaxing? _____ How do you relax? _____

How many hours of sleep do you get, generally? _____ Do you use any sleep aids? _____

Do you struggle with falling asleep or staying asleep? _____

Do you wake up during the night? _____ If so, at what time(s) _____

Describe your sleep habits: _____

Do you wake feeling refreshed and alert? _____ Do you take naps during the day? _____

What are your hobbies and interests? _____

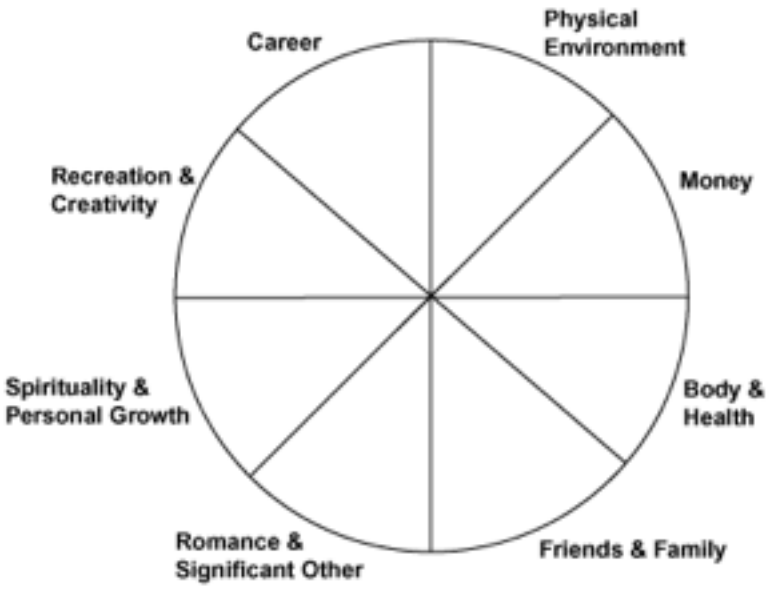
Do you have a spiritual/religious practices? _____

Circle of Life:

Use a pen to shade in the amount of each slice of the pie to match your level of satisfaction in that life category.

The more you shade in, the higher your satisfaction in that category. The less you shade in, the lower your satisfaction in that category.

This exercise will allow you and I to see your life as a whole, and identify potential areas of focus during our sessions together.



Diet

How many meals do you eat a day? _____ Do you eat at regular meal times? _____

Where do you usually eat your meals? _____

Do you like to cook? _____ On average, what percentage of your meals are cooked at home? _____

What percentage of meals do you eat at a restaurant/take out? _____Favorite Spots?_____

Where do you usually buy your food? _____

Are you satisfied after eating a meal? _____ If not, please explain: _____

Do you snack? _____ How often and when? _____

How much water do you generally drink each day? _____What types of foods do you crave? _____

_____How often do you have cravings? _____

Are they at regular times? _____ If so, when? _____

Do you have any food allergies or sensitivities? _____ Please describe your reactions: _____

_____

As a child, what type of foods did you eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks and Desserts: _____

Liquids: _____

Currently, what type of foods do you eat for:

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks and Desserts: _____

Liquids: _____

Are you satisfied with your current diet?_____ If not, what would you like to change? _____

Have you ever had an eating disorder? _____ If so, when and for how long? _____

24 Hour Recall: Please list all foods and beverages you consumed yesterday. Include time and amount, if possible.

_____

_____

_____

Digestion and Elimination:

How often do you have bowel movements? _____Do you have gas, bloating, or fullness after you eat? _____

How often? _____ On a scale of 1 to 10 (10 = highest), how severe? _____

Do you experience constipation or diarrhea? _____

How often? _____ On a scale of 1 to 10 (10 = highest), how severe? _____

Any blood, mucus or undigested food particles in your stool? _____

Do you experience any rectal itching? _____ Do you experience heartburn or indigestion? _____

Have you taken digestive enzymes? _____ If so, what was the outcome?_____

How does stress effect your digestion? _____

Additional Information and Notes

Please include any other information that you would like to share with me, or that you feel will be beneficial to our work together.