
# CLIENT INTAKE FORM

Name: _____

DOB: _____ Gender: ☐ M ☐ F ☐ Other

Address: _____

Phone number (H): _____ (M): _____

Email address: _____

Occupation: _____

Nationality/Religion: _____

Marital Status: _____

Pregnant: ☐ No ☐ Yes If yes, how many weeks? _____

GPs name: _____ Phone number: _____

Have you had any issues with natural health care practitioners previously:

_____

Allergies/intolerance:

_____

Current medications:

_____

_____

Past medications:

_____

_____

Nutritional Supplements/Vitamins/Homeopathic Remedies/Herbs:

_____

_____

Surgeries/accidents/injuries:

_____

_____

Any other health issues:

_____

_____

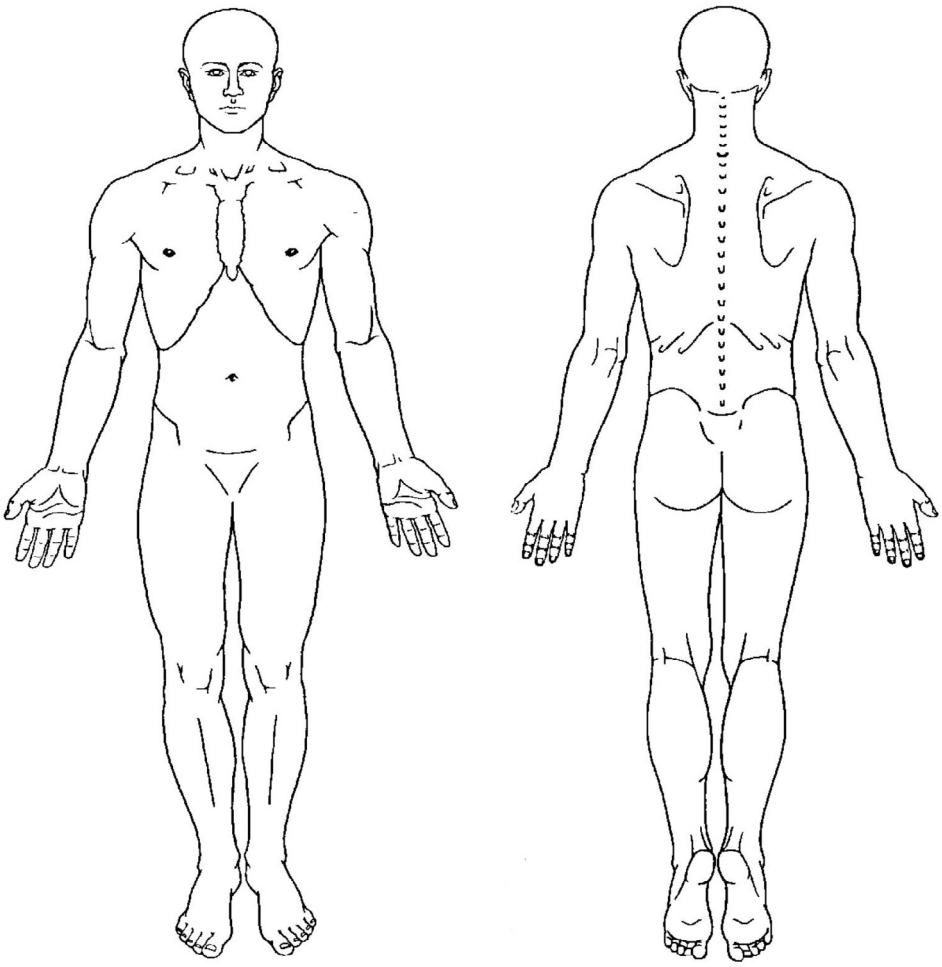
Date: _____

| Head to Toe | Comments |
|---|---|
| Headaches<br>o Parietal, vertex, behind eyes | |
| Memory | |
| Dizziness<br>o General, on standing | |
| Sinus problems | |
| Hearing<br>o Tinnitus - loud or soft | |
| Eyes / Vision<br>o Red, blurry, floaters, dry | |
| Mouth<br>o Taste - bitter, metallic etc<br>o Amalgam (silver) fillings<br>o Cold sores<br>o Mouth ulcers<br>o Teeth issues<br>o Dry, rough, furry tongue | |
| Throat problems<br>o Tonsils removed<br>o Constant phlegm | |
| Heart trouble | |
| Blood pressure<br>o Normal / low / high<br>o Palpitations | |
| Circulation problems<br>o Cold hands/feet<br>o Numbness | |
| Breathing<br>o Asthma<br>o Shortness of breath | |
| Immunity / Allergies<br>o Skin - eczema, psoriasis<br>o Dry nails, hair, lips | |

| Head to Toe | Comments |
|---|---|
| Urinary<br>o Water intake per day<br>o Waking at night for toilet<br>o Other urinary issues | |
| Pain<br>o General<br>o Local (knees, low back etc) | |
| Bone Density<br>o Osteoporosis/Osteopenia<br>o Arthritis location | |
| Digestion<br>o Bowel movements how often<br>o Bloating<br>o Food sensitivities or allergies<br>o Food preferences<br>o Tired after meal | |
| Energy levels<br>o Rate from 1-10 (10 = high)<br>o On waking (tired / refreshed)<br>o Mid-afternoon slump | |
| Diabetes<br>o Age at onset<br>o Type 1 or type 2<br>o How often do you measure blood glucose<br>o Family history of diabetes | |
| Metabolism<br>o Feel more hot / cold?<br>o Prefer cold / hot drinks? | |
| Thyroid Issues | |
| Stress levels<br>o Rate from 1-10 (10 = high) | |
| Sleep<br>o How many hours/night<br>o Light or heavy<br>o Trouble getting to sleep / staying asleep<br>o Dreams – vivid | |
| Menstrual cycle<br>o Regular<br>o Pain – before, during, after<br>o Breast distension<br>o Menopause | |

| Head to Toe | Comments |
|---|---|
| Hormonal/Adrenal Issues | |
| Vaccinations<br>o Date of last vaccination | |
| Epilepsy<br>o Last seizure<br>o Do seizure last longer than 2 minutes | |
| Exercise<br>o Type and frequency | |
| Smoking<br>o Past/present<br>o How many per day | |
| Alcohol consumption<br>o Glasses per week? | |
| Non prescribed drugs<br>o Past/present<br>o How often | |
| Cancer<br>o Past/current<br>o Type/location | |
| Other diagnostic tests undertaken?<br>X-Ray, MRI, CT Scan etc. | |

# INDICATE THE LOCATION OF YOUR PAIN ON THE DIAGRAM:



If there were one thing you could change, what would it be?

Is there a strong emotion that you have been feeling lately?

Anything to add?