Intake Questionnaire

Personal Information

Legal first name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Medical Insurance

Policy Holder

Legal first name

Last name

Date of birth

Phone number

Gender

Street

Unit

City

State/Province

Postal code

Insurance Company

Member Id

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Have you ever taken antibiotics? Yes No

Have you ever taken birth control? Yes No

Have you ever been on hormone replacement therapy? Yes No

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

List your current health concerns in order of importance

Health Concerns

Do you experience digestive difficulties?
(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement? Yes No

Are your bowels loose? Yes No

Do you take laxatives? Yes No

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Do you avoid these foods? Yes No

Diet

How much water do you drink daily?

Do you consume coffee? Yes No

Do you consume tea? Yes No

Do you consume alcohol? Yes No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Do you experience any symptoms after meals?

Describe your relationship with food
Please be very specific

Untitled question

Policy Holder	Legal first name	Last name

Date of birth

Gender

Insurance Company	Payer Id	Coverage Type

Member Id	Plan Id	Group Id

Copay	Deductible

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? You wake frequently during the night?

Do you wake feeling rested? Yes No

How often do you exercise?

What types of exercise do you do?

What do you do to have fun?

How do you express your creativity?

Do you have any pets? Yes No

What level of stress are you currently experiencing?

List your main stressors

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

How many hours per day do you use a computer?

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How many hours per day do you use a cell phone?

How many hours per day do you use watch TV?

Chemicals

Where did you grow up?
City or country?

City Country

What type of environment do you/ have you worked in?

How many cigarettes do you smoke per day?

For how many years? If you quit, how long ago?

Do you or have you used recreational drugs?

Yes No

Have you had any dental work done?
Do you have fillings (metal), root canals, crowns, etc?

Have you ever had shots/vaccinations?
List all that apply (including flu shots)

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

1 2 3 4 5 6 7 8 9 10

1 = Lowest, 10 = Highest