replenish pdx Client Intake Form

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

Client Information

Name _____

Address _____

City _____

State _____

Zip Code _____

Phone (day) _____

Phone (cell) _____

Phone (night) _____

Email _____

Referred by _____

Statistics

Age _____

Birth Date _____

Gender _____

Height _____

Blood Type _____

Birth Weight (if known) _____

Current Weight _____

Ideal Weight _____

Weight One Year Ago _____

Family/Living Situation: _____

Children: _____

Occupation: _____

Exercise/Recreation: _____

History

1. Have you lived or traveled outside of the United States? If so, when and where?:

2. Have you or your family recently experienced any major life changes? If so, please comment:

3. Have you experienced any major losses in life? If so, please comment:

4. How much time have you had to take off from work or school in the last year?

   - ☐ 0 to 2 days
   - ☐ 3 to 14 days
   - ☐ more than 15 days

Health Concerns

5. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

6. When did you first experience these concerns?

7. How have you dealt with these concerns in the past?

   - ☐ doctors
   - ☐ self-care

8. Have you experienced any success with these approaches?

9. What other health practitioners are you currently seeing? List name, specialty and phone # below.

10. Please list the date and description of any surgical procedures you have had.

11. How often did you take antibiotics in infancy/childhood?

12. How often have you taken antibiotics as a teen?

13. How often have you taken antibiotics as an adult?

14. List any medicine you are currently taking:

15. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

16. Have any other family members had similar problems (describe)?

Nutritional Status

17. Are there any foods that you avoid because of the way they make you feel?
    If yes, please name the food and the symptom:

18. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives?
    If so, please explain:

19. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

20. Are there foods that you crave? If so, please explain:

21. Describe your diet at the onset of your health concerns:

22. Do you have any known food allergies or sensitivities?

23. Which of the following foods do you consume regularly?

- ☐ soda
- ☐ diet soda
- ☐ refined sugar
- ☐ alcohol
- ☐ fast food
- ☐ gluten (wheat, rye, barley)
- ☐ dairy (milk, cheese, yogurt)
- ☐ coffee

24. Are you currently on a special diet?

- ☐ autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ Other (please describe)
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free

25. What percentage of your meals are home-cooked?

- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60
- ☐ 70
- ☐ 80
- ☐ 90
- ☐ 100

26. Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

27. Bowel Movement Frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

28. Bowel Movement Consistency

- ☐ soft & well formed
- ☐ often float
- ☐ difficult to pass
- ☐ diarrhea
- ☐ thin, long or narrow
- ☐ small and hard
- ☐ loose but not watery
- ☐ alternating between hard and loose

29. Bowel Movement Color

- ☐ medium brown
- ☐ very dark or black
- ☐ greenish
- ☐ blood is visible
- ☐ variable
- ☐ yellow, light brown
- ☐ chalky colored
- ☐ greasy, shiny

30. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

31. Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

Medical Status

32. Please check any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

- ☐ Cancer
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Venereal Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Chronic Yeast Infections

Health Hazards

33. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

34. Do odors affect you?

35. Are you or have you been exposed to second-hand smoke?

36. Do you have mercury amalgam fillings?

Lifestyle History

37. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

38. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

39. How do you handle stress?

Sleep History

40. Are you satisfied with your sleep?

41. Do you stay awake all day without dozing?

42. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

43. Do you fall asleep in less than 30 minutes?

44. Do you sleep between 6 and 8 hours per night?

For Women Only

45. How are/were your menses? Do/did you have PMS? Painful periods: If so, explain.

46. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

47. Have you experienced any yeast infections or urinary tract infections? Are they regular?

48. Have you/do you still take birth control pills: If so, please list length of time and type.

49. Have you had any problems with conception or pregnancy?

50. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Sexual History

51. Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

52. In the past year, have your sexual partners been men, women, or both? And how many partners have you had in the past year?

Mental Health Status

53. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

54. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

55. At what point in your life did you feel best? Why?

Other

56. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

57. Who in you family or on your health care team will be most supportive of you making dietary change?

58. Please describe any other information you think would be useful in helping to address your health concern(s):

59. What are your health goals and aspirations?

60. Though it may seem odd, please consider why you might want to achieve that for yourself: