CLIENT INTAKE & ASSESSMENT FORM

The information provided in this form will be kept strictly confidential and is protected from misuse, loss or unauthorized modification, disclosure or access.

Client Information

Date: _____

Name: _____

Phone: _____

Email: _____

Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Common Law

Personal Profile Information

Gender: ☐ Male ☐ Female ☐ Trans ☐ Gender nonconforming

Age: _____ **Height:** _____ **Ethnicity:**

Weight NOW: _____ **Goal Weight** (if applicable)**:** _____ **Body fat %**

Physical Activity

Explain in detail what type of resistance exercises, cardiovascular or sports activities you preform on average during a 7-day period:

Exercise/Activity	Days/week	Duration

Add any further notes here regarding your level of exercise and training:

How would you rate your activity level, including what you do during the day (ie take into account your job if it is physical in nature). Select one ☛

☐ Sedentary ☐ Moderately Active ☐ Active ☐ Very Active

Do you feel fatigued after exercise? If so, describe ☛

Body Type & Diet History

Which of the following statements best describes you?

Check one ☛

- ☐ I can eat practically anything I want and I don't gain weight.
- ☐ I find it very hard to gain weight.
- ☐ I can lose or gain weight by adjusting my activity level and eating habits.
- ☐ I find it difficult to lose weight.
- ☐ I can gain weight easily and have to watch what I eat.

Have you ever been placed on any type of nutritional program in the past?

☛ ☐ Yes ☐ No

If yes, by whom and what did it consist of? Please explain below.

What were your results?

What were the biggest challenges?

What is Your Main Health Concern? (describe with symptoms & duration)

When did your health problem first begin?

What else was going on in your life at that time? (Ie change in diet, physical activity, job, relationships, and any additional details you remember.)

What makes you feel worse?

What makes you feel better?

Sleep Profile

What time do you normally go to bed and wake up?

How long does it take you to fall asleep?

Do you wake up feeling rested?

Do you use sleep aids? If so what kind:

Family History & Lifestyle Profile

Do you have children?

What are their ages ☛

Occupation:

Have you or your family experienced any significant recent life changes?
Please explain ☛

Have you experienced any major losses in life?
Please explain ☛

Daily Stressors: Rate each on a scale of 1-10

Family _____ Work_____ Health _____ Finances _____ Social _____ Other _____

Family history:

Family Member	Age(s)	Health Status
Mother		
Father		
Sister(s)		
Brother(s)		

Have you ever been hospitalized? If yes, when? Why?

List any surgeries you have had:

Vaccinations and/or Flu shots? Include approximate age.

How have you dealt with your health concerns in the past?

Check all that apply ☛

- [ ] Doctor
- [ ] Practitioner (type? _____)
- [ ] Self care
- [ ] Dietitian

What other health practitioners are you currently seeing? (list name, specialty)

How often did you take antibiotics as a child & teen?

☛ Please list infections being treated and approximate ages.

How often did you take antibiotics as an adult?

☛ Please list infections treated and date estimates.

Psychosocial

	YES	NO
Do you feel less vital than you did one year ago?	☐	☐
Do you like yourself as you are today?	☐	☐
Do you feel confident?	☐	☐
Do you believe stress is currently reducing your quality of life?	☐	☐
Do you feel your life has meaning and purpose?	☐	☐
Do you like the work you do?	☐	☐
Do you spend the majority of your time and money to fulfill responsibilities and obligations?	☐	☐
Do you find it difficult to trust others?	☐	☐
Do you often feel overwhelmed by life?	☐	☐
Do you practice meditation or relaxation techniques?	☐	☐
Have you ever been abused or experienced a significant trauma?	☐	☐

Do any events/moments in your life stand out as being more stressful?
If yes, describe:

What do you worry about most in your life?

What do you do to relieve stress and relax?

Have you tried any relaxation techniques? Choose all that apply					
☐	Yoga	☐	Meditation	☐	Tai Chi
☐	Deep breathing	☐	Imagery	☐	Prayer

Dietary Profile

Do you have any food allergies? ☛ ☐ Yes / No ☐

If yes, please list the foods:

Do you have any food sensitivities? ☛ ☐ Yes / No ☐

If yes, please list the foods:

Have you been tested for food sensitivities or is the above based on reaction to the food consumed?

Please list foods that you will not eat under any circumstances:

What do you eat and use? How often?

Please indicate next to the selection “1” for rarely, “2” for regularly,“3” for often ☛

	Aluminum pans		Margarine		Fried foods
	Microwave		Candy/chocolate/sugar		Packaged foods
	Luncheon meats		Splenda/Aspartame		Fast foods

How many cups of the following do you drink per day?

	Bottled Water		Red Wine		Filtered Water
	Tap Water		Fresh Fruit Juice		Alcohol
	Reduced Fat Milk		Soy Milk		Non-Diet Soft Drinks
	Diet Soft Drinks		Vegetable Juice (fresh)		Full Fat Milk

How many ½ cup servings of each do you typically eat in a day?

- [ ] Fruit
- [ ] Vegetables
- [ ] Whole Grains
- [ ] Protein
- [ ] Dairy

What are your favorite foods?

Do you experience any symptoms if meals are missed?
Please explain ☛

Do you experience any symptoms after meals? (ie bloating, gas, fatigue etc)
Please explain ☛

Are there foods you avoid because of how they make you feel?
Include the food & symptoms ☛

Do you currently follow a special diet or nutritional program?

Choose all that apply:

	Low-fat		Low-Carb		High-Protein
	Low-sodium		Dairy-free		Diabetic
	Gluten-free		Vegetarian		Vegan

Do you grocery shop? ☐ Yes ☐ No

If no, who does the shopping?

If you could only eat a few foods a week, what would they be?

Do you cook? ☐ Yes ☐ No

If no, who does the cooking?

Do you read food labels? ☐ Yes ☐ No

Do you count calories? ☐ Yes ☐ No

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Have you made any changes in your eating habits because of your health?

☐ Yes ☐ No

If yes, explain:

Dental Profile

Choose all that apply:

☐	Mercury fillings	☐	Tooth pain	☐	Gingivitis
☐	Root canals	☐	Bleeding gums	☐	Composite fillings
☐	Ulcers/lesions	☐	Problems chewing	☐	Floss regularly

Supplements & Medications

List vitamins/supplements/enhancers/herbs are you currently taking, including brand name if possible:

Type & Brand	Dosage	Frequency	Reason for Use	Start Date

List prescription medications you are currently taking or have taken in the last 5 years:

Medication	Dosage	Frequency	Reason for Use	Start/End Date

Do your medications or supplements ever cause unusual side effects or problems?

☐ Yes ☐ No

If yes, indicate which supplement or medication and describe side effects:

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.)? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blocking Drugs (Zantac, Prilosec, etc.)?

☐ Yes ☐ No

Antibiotics use more than 3 times/year? ☐ Yes ☐ No

Long term antibiotics at any time during your life? ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

If yes, how often and what type (all answers are confidential) ☛

Do you use Marijuana or CBD therapeutically? ☐ Yes ☐ No

If yes, what forms and how often (edibles, oils, etc):

If you use CBD please indicate the dosage, frequency, and what you use it for:

Do you smoke? ☐ Yes ☐ No

How many years? Packs per day:

Previous smoking: How many years? Packs per day:

Second hand smoke exposure?

Symptomatology Assessment

Please indicate frequency of issue or symptoms:

0 = Never / 1 = Rarely occurs / 2 = Moderate (Frequently occurs) / 3 = Severe (Daily or weekly)

Section 1: Adrenal Health	0	1	2	3	Notes:
Fatigue in the afternoon	☐	☐	☐	☐	
Trouble staying asleep	☐	☐	☐	☐	
Cravings for salty food	☐	☐	☐	☐	
Dizziness when standing quickly	☐	☐	☐	☐	
Slow start in mornings	☐	☐	☐	☐	
Eyes sensitive to bright light	☐	☐	☐	☐	
Grinding teeth	☐	☐	☐	☐	
Difficulty falling asleep	☐	☐	☐	☐	
Hives	☐	☐	☐	☐	
Perspire often with no activity	☐	☐	☐	☐	
Wake up tired even after enough sleep	☐	☐	☐	☐	
Weak nails	☐	☐	☐	☐	
Afternoon headaches	☐	☐	☐	☐	
Trouble recovering from stress	☐	☐	☐	☐	
Headache with exertion or exercise	☐	☐	☐	☐	
Under a high amount of stress	☐	☐	☐	☐	

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Section 2: Vitamin / Mineral	0	1	2	3	Notes:
Loss of muscle tone	☐	☐	☐	☐	
Small bumps on back of arms	☐	☐	☐	☐	
Racing heart	☐	☐	☐	☐	
Numbness or tingling	☐	☐	☐	☐	
Feeling depressed	☐	☐	☐	☐	
Gums bleed easily	☐	☐	☐	☐	
Body jerks when falling asleep	☐	☐	☐	☐	
Persistent worry or anxiety	☐	☐	☐	☐	
Bruise easily	☐	☐	☐	☐	
Nosebleeds	☐	☐	☐	☐	

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Section 3: Colon Health	0	1	2	3	Notes:
Feeling bowels do not empty completely	☐	☐	☐	☐	
Diarrhea	☐	☐	☐	☐	
IBS or colitis	☐	☐	☐	☐	
History of parasites	☐	☐	☐	☐	
Yeast infections	☐	☐	☐	☐	
Itchy anus	☐	☐	☐	☐	
Itchy skin	☐	☐	☐	☐	
Nail fungus	☐	☐	☐	☐	
“Fuzzy” tongue	☐	☐	☐	☐	
Loose stools	☐	☐	☐	☐	
Lack of daily bowel movements	☐	☐	☐	☐	
Abdominal cramping	☐	☐	☐	☐	
Use laxatives	☐	☐	☐	☐	
Pass bad smelling gas	☐	☐	☐	☐	
Abdominal pain relieved by passing gas or having a bowel movement	☐	☐	☐	☐	
Blood in stool	☐	☐	☐	☐	
More than 3 bowel movements per day	☐	☐	☐	☐	
Alternating diarrhea and constipation	☐	☐	☐	☐	
Hemorrhoids	☐	☐	☐	☐	
Celiac disease	☐	☐	☐	☐	
Bloating after consuming grains	☐	☐	☐	☐	
Belching	☐	☐	☐	☐	
Heartburn	☐	☐	☐	☐	
Nausea or Vomiting	☐	☐	☐	☐	
Diverticulitis	☐	☐	☐	☐	

Bowel movement frequency:	Bowel Color:	Bowel consistency:
☐ Lots of toilet paper needed	☐ Very Dark or Black	☐ Soft & Well Formed
☐ Skinny stool	☐ Yellow, Light Brown	☐ Hard & Painful
☐ Floating	☐ Greasy/Shiny	☐ Watery & Loose

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Section 4: Thyroid Health	0	1	2	3	Notes:
Night sweats	☐	☐	☐	☐	
Flush easily	☐	☐	☐	☐	
Difficulty gaining weight	☐	☐	☐	☐	
Easily fatigued	☐	☐	☐	☐	
Cold hands and feet	☐	☐	☐	☐	
Low body temperature	☐	☐	☐	☐	
Sensitivity to cold	☐	☐	☐	☐	
Intolerant to heat	☐	☐	☐	☐	
Heart palpitations	☐	☐	☐	☐	
Insomnia	☐	☐	☐	☐	
Fast resting pulse	☐	☐	☐	☐	
Thinning hair or hair loss	☐	☐	☐	☐	
Thinning of lateral 1/3 of eyebrows	☐	☐	☐	☐	
Morning headaches that go away	☐	☐	☐	☐	
Stubborn easy weight gain	☐	☐	☐	☐	
Lack of motivation or depression	☐	☐	☐	☐	
Nervousness	☐	☐	☐	☐	
Excessively sleeping	☐	☐	☐	☐	
Dry skin	☐	☐	☐	☐	
Puffy face	☐	☐	☐	☐	
Weakness and aches in muscles and joints	☐	☐	☐	☐	

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Section 5: Respiratory Health	0	1	2	3	Notes:
Asthma	☐	☐	☐	☐	
Chronic sinusitis	☐	☐	☐	☐	
Exercise induced asthma	☐	☐	☐	☐	
Sleep apnea	☐	☐	☐	☐	
Pneumonia	☐	☐	☐	☐	
Emphysema	☐	☐	☐	☐	
Bronchitis	☐	☐	☐	☐	

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Section 6: Liver & Gallbladder Health	0	1	2	3	Notes:
Insomnia	☐	☐	☐	☐	
Stomach gets upset after eating greasy or high-fat foods	☐	☐	☐	☐	
Metallic taste in mouth in the morning	☐	☐	☐	☐	
Eyes are yellow	☐	☐	☐	☐	
Excessive hair loss	☐	☐	☐	☐	
Sensitivity to perfume	☐	☐	☐	☐	
Sensitivity to chemicals	☐	☐	☐	☐	
Easily intoxicated after a small amount of alcohol	☐	☐	☐	☐	
Pain under rib cage on right side	☐	☐	☐	☐	
Fish-tasting burps after taking fish oil	☐	☐	☐	☐	
Palms of hands look red	☐	☐	☐	☐	
Gallstones or gallbladder attack	☐	☐	☐	☐	
Weight gain	☐	☐	☐	☐	
Nausea	☐	☐	☐	☐	
Motion sickness	☐	☐	☐	☐	
Gas and bloating for hours after eating	☐	☐	☐	☐	
Unexplained swelling in legs and ankles	☐	☐	☐	☐	
Pain between shoulder blades	☐	☐	☐	☐	
Headache over eyes	☐	☐	☐	☐	
Stool color looks like grey clay	☐	☐	☐	☐	
Hemorrhoids	☐	☐	☐	☐	
Alcohol abuse	☐	☐	☐	☐	
Itchy and/or peeling feet	☐	☐	☐	☐	
Chronic fatigue	☐	☐	☐	☐	
Dark coloured urine	☐	☐	☐	☐	

Do you have any of the following conditions? Check the selection(s) that apply					
☐	Hepatitis	☐	Wilson's Disease	☐	Gallstones
☐	Cirrhosis	☐	AIDS	☐	Non-alcoholic Fatty liver disease

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Section 7: Endocrine & Blood Sugar Health	0	1	2	3	Notes:
Crave sweets, alcohol or coffee	☐	☐	☐	☐	
Difficulty losing weight	☐	☐	☐	☐	
Need sweets after a meal	☐	☐	☐	☐	
Waist girth is equal to or larger than hip girth	☐	☐	☐	☐	
Increased thirst	☐	☐	☐	☐	
Frequent urination	☐	☐	☐	☐	
Rely on coffee or sugar to get going and stay going	☐	☐	☐	☐	
Eating relieves fatigue	☐	☐	☐	☐	
Crave sugar after eating it	☐	☐	☐	☐	
Blurred vision	☐	☐	☐	☐	
Difficulty with memory	☐	☐	☐	☐	
Feeling foggy headed	☐	☐	☐	☐	
Feel shaky when hungry	☐	☐	☐	☐	
Easily agitated or nervous	☐	☐	☐	☐	
Get light headed if a meal is late or missed	☐	☐	☐	☐	
Get a headache if a meal is late or missed	☐	☐	☐	☐	
Sudden weakness or shakiness	☐	☐	☐	☐	
Night hunger	☐	☐	☐	☐	
Experience hunger after eating	☐	☐	☐	☐	
Sleepy in the afternoon	☐	☐	☐	☐	
Binge or uncontrolled eating	☐	☐	☐	☐	
Wake up a few hours after falling asleep & have trouble getting back to sleep	☐	☐	☐	☐	

Do you have any of the following conditions? Check the selection(s) that apply					
☐	Hypothyroidism	☐	Hypoglycemia	☐	Type 1 diabetes
☐	Hyperthyroidism (Graves)	☐	Metabolic syndrome	☐	Type 2 diabetes
☐	Addison's Disease	☐	Chronic Fatigue Syndrome	☐	Cushing's Syndrome

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Section 8: Neurological Health	0	1	2	3	Notes:
Concentration or memory problems	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	
Irritability	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Anxiety / panic attacks	☐	☐	☐	☐	
Worry	☐	☐	☐	☐	
Mood swings	☐	☐	☐	☐	
Vivid dreams	☐	☐	☐	☐	
Attention problems	☐	☐	☐	☐	
Nightmares	☐	☐	☐	☐	

Do you have any of the following conditions? Check the selection(s) that apply					
☐	ADD/ADHD	☐	Bipolar disorder	☐	Anxiety disorder
☐	Clinical depression	☐	Schizophrenia	☐	Traumatic Brain Injury

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Section 9: Stomach Health	0	1	2	3	Notes:
Diarrhea after meals	☐	☐	☐	☐	
Fingernails that break easily	☐	☐	☐	☐	
Strong body odour	☐	☐	☐	☐	
Undigested food in stool	☐	☐	☐	☐	
Heartburn or acid reflux	☐	☐	☐	☐	
Gas, burping or bloating after meals	☐	☐	☐	☐	
Bad breath	☐	☐	☐	☐	
Feeling hungry after eating a meal	☐	☐	☐	☐	
Feel better when not eating	☐	☐	☐	☐	
Feeling overfull after meals	☐	☐	☐	☐	
Heartburn after spicy food, chocolate or caffeine	☐	☐	☐	☐	
Digestive problems improve after rest	☐	☐	☐	☐	
Antacids bring relief to digestive issues	☐	☐	☐	☐	
Stomach pain or burning after meals	☐	☐	☐	☐	

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Section 10: Digestive Reactions	0	1	2	3	Notes:
Increased pulse after eating	☐	☐	☐	☐	
Sinus congestion	☐	☐	☐	☐	
Alternating constipation and diarrhea	☐	☐	☐	☐	
Bloating after eating starches	☐	☐	☐	☐	
Hives or welts after eating	☐	☐	☐	☐	
Excess gas after meals	☐	☐	☐	☐	
Feeling full for hours after eating	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	
Gluten sensitivity	☐	☐	☐	☐	
Feeling overfull after meals	☐	☐	☐	☐	
Cravings for bread and pasta	☐	☐	☐	☐	
Increasing food reactions	☐	☐	☐	☐	
Frequent urination	☐	☐	☐	☐	
Feel zoned out after eating	☐	☐	☐	☐	
Constipation after eating fiber	☐	☐	☐	☐	
Aches, pains and swelling	☐	☐	☐	☐	
Yeast infection	☐	☐	☐	☐	
Dark circles under eyes	☐	☐	☐	☐	
Nail fungus	☐	☐	☐	☐	

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Section 11: Immune Health	0	1	2	3	Notes:
Runny nose or nasal drip	☐	☐	☐	☐	
Swollen lymph nodes	☐	☐	☐	☐	
Cold and flu	☐	☐	☐	☐	
Shingles	☐	☐	☐	☐	
Cold sores	☐	☐	☐	☐	
Herpes	☐	☐	☐	☐	
Poor wound healing	☐	☐	☐	☐	
Dry/irritated or itchy eyes	☐	☐	☐	☐	
Mucus in throat	☐	☐	☐	☐	
Sinus or ear infections	☐	☐	☐	☐	

Do you have any of the following autoimmune conditions? Check the selection(s) that apply					
☐	Lupus	☐	Sjogren's syndrome	☐	Raynaud's
☐	Rheumatoid arthritis	☐	Multiple sclerosis	☐	Inflammatory Bowel Disease
☐	Vasculitis	☐	Psoriasis	☐	Hashimoto's

Pre-Menopausal Women Only:

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Section 12: Menstruation Health	0	1	2	3	Notes:
Perimenopausal	☐	☐	☐	☐	
Night sweats and/or hot flashes	☐	☐	☐	☐	
Vaginal itchiness	☐	☐	☐	☐	
Fibrocystic breasts	☐	☐	☐	☐	
Uterine fibroids	☐	☐	☐	☐	
Facial hair growth	☐	☐	☐	☐	
Length of cycle varies each month	☐	☐	☐	☐	
Cycle is less than 24 days	☐	☐	☐	☐	
Light blood flow during cycle	☐	☐	☐	☐	
Heavy blood flow during cycle	☐	☐	☐	☐	
Irritable and/or depressed	☐	☐	☐	☐	
Acne that does not clear up	☐	☐	☐	☐	
Hair loss	☐	☐	☐	☐	
Yeast infections	☐	☐	☐	☐	
Breast pain and swelling during cycle	☐	☐	☐	☐	
Decreased libido	☐	☐	☐	☐	
Mood swings	☐	☐	☐	☐	
Loss of control of urine	☐	☐	☐	☐	
Palpitations	☐	☐	☐	☐	

Do any of the following apply to you? Check the selection(s) that apply					
☐	On birth control pill	☐	Breast implants	☐	Have/had breast cancer
☐	Have an IUD	☐	Taking HRT	☐	Are pregnant or nursing
☐	Endometriosis	☐	Post partum depression	☐	Hysterectomy

Menopausal/Post Menopausal Women Only:

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Section 13: Menstruation Health	0	1	2	3	Notes:
Mental fogginess	☐	☐	☐	☐	
Decreased interest in sex	☐	☐	☐	☐	
Mood swings	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Acne	☐	☐	☐	☐	
Facial hair growth	☐	☐	☐	☐	
Vaginal pain, itching, dryness	☐	☐	☐	☐	
Shrinking breasts	☐	☐	☐	☐	
Hot flashes	☐	☐	☐	☐	
Painful intercourse	☐	☐	☐	☐	
How many years have you been menopausal?					

Men Only:

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Section 14: Male Health	0	1	2	3	Notes:
Depression	☐	☐	☐	☐	
Uncontrollable sweating	☐	☐	☐	☐	
Difficulty maintaining erection	☐	☐	☐	☐	
Difficulty concentrating	☐	☐	☐	☐	
Muscle soreness	☐	☐	☐	☐	
Pain or burning when urinating	☐	☐	☐	☐	
Difficulty or dribbling when urinating	☐	☐	☐	☐	
Decreased physical stamina	☐	☐	☐	☐	
Decreased libido	☐	☐	☐	☐	
Sinus or ear infections	☐	☐	☐	☐	
Feeling of incomplete bowel emptying	☐	☐	☐	☐	
Have you had a prostate-specific antigen (PSA) test done?					

Health & Medical Conditions

Do you have any other medical condition that has not been addressed above?

Please list ☛

Client Statement

I, _____ agree to allow _____, to design a program for me to enhance my health. I understand that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment, or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This program does not replace the expert advice or medical treatment of my own doctor. I have given _____ all necessary information about myself to prevent any possible complications.

Signature: _____**Date:** _____