Naturally Guided Health

# Intake Form

Today's Date: _____-_____-_____

| | | |
|---|---|---|
| Name: | Birthday: | Age: |
| Email: | | |
| Address: | | |
| City: | State: | Zip: |
| Cell: | Home: | Work: |
| Occupation: | | Hours per week of work: |
| Relationship Status: | | |
| Children: | If so, their ages: | |
| Pets: | Types: | |
| Height: | Weight: | Weight One year ago: |

Main Complaints: *List your present health problems:*

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

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

_____

What are your health goals? _____

_____

Have you had any labwork done within the past year? _____- If yes, please email to me with your completed intake form.

Please list ALL medications or nutritional supplements you are currently taking:

_____

_____

_____

**Health History:**

*List any surgeries or major illnesses with approximate dates.*

| Illness: | Dates: | Recovered?: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*List any family history of serious illnesses: circle all that apply.*

Cancer: Type: _____ Relation: _____

Diabetes: Type: _____ Relation: _____

Heart Disease: Type: _____ Relation: _____

Other: _____ Type: _____ Relation: _____

_____ Type: _____ Relation: _____

Please circle all that apply. Follow key below.
Key: 0=none symptom does not occur; 1=Yes, mild symptom, rarely occurs; 2=Moderate symptom, occurs weekly; 3=Severe symptom, occurs daily

## Stomach:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Heartburn or Acid Reflux |
| 0 | 1 | 2 | 3 | Burping or Gas after eating |
| 0 | 1 | 2 | 3 | Bloating after eating |
| 0 | 1 | 2 | 3 | Bad Breath |
| 0 | 1 | 2 | 3 | Sweat has a strong odor |
| 0 | 1 | 2 | 3 | Feel better if I don't eat |
| 0 | 1 | 2 | 3 | Sleepy after meals |
| 0 | 1 | 2 | 3 | Burning pain in stomach |
| 0 | 1 | 2 | 3 | Fingernails chip/break/peel |
| 0 | 1 | 2 | 3 | Anemia Unresponsive to iron |
| 0 | 1 | 2 | 3 | Stomach pain or cramps |
| 0 | 1 | 2 | 3 | Diarrhea, chronic |
| 0 | 1 | 2 | 3 | Diarrhea after meals |
| 0 | 1 | 2 | 3 | Black or dark stool |
| 0 | 1 | 2 | 3 | Undigested food in stool |
| Total: | | | | |

## Large Intestine:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Skip days between bowels movements |
| 0 | 1 | 2 | 3 | Stools hard or difficult to pass |
| 0 | 1 | 2 | 3 | Cramping on lower abdomen |
| 0 | 1 | 2 | 3 | Mucus in stool |
| 0 | 1 | 2 | 3 | IBS or colitis |
| 0 | 1 | 2 | 3 | Yeast infections |
| 0 | 1 | 2 | 3 | Nail fungus or athletes foot |
| 0 | 1 | 2 | 3 | Dark circles under eyes |
| 0 | 1 | 2 | 3 | History of parasites |
| 0 | 1 | 2 | 3 | Coated tongue |
| 0 | 1 | 2 | 3 | Anus itches |
| 0 | 1 | 2 | 3 | Constipation |
| 0 | 1 | 2 | 3 | Stools are loose |
| 0 | 1 | 2 | 3 | Bad smelling gas |
| Total: | | | | |

## Small Intestine:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Food allergies |
| 0 | 1 | 2 | 3 | Bloating after eating |
| 0 | 1 | 2 | 3 | Airborne allergies |
| 0 | 1 | 2 | 3 | Wheat or gluten sensitivity |
| 0 | 1 | 2 | 3 | Dairy sensitivity |
| 0 | 1 | 2 | 3 | Sinus congestion |
| 0 | 1 | 2 | 3 | Craves bread/pasta |
| 0 | 1 | 2 | 3 | Pulse speeds after eating |
| 0 | 1 | 2 | 3 | Nightmares |
| 0 | 1 | 2 | 3 | Feel spacy or unreal |
| 0 | 1 | 2 | 3 | Alternating diarrhea/constipations |
| 0 | 1 | 2 | 3 | Hives |
| Total: | | | | |

## Liver:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Nausea |
| 0 | 1 | 2 | 3 | Pain between shoulder blades |
| 0 | 1 | 2 | 3 | Skin rashes/acne/eczema |
| 0 | 1 | 2 | 3 | Age or “Liver” spots |
| 0 | 1 | 2 | 3 | Greasy foods upset stomach |
| 0 | 1 | 2 | 3 | Gallbladder attacks or stones |
| 0 | 1 | 2 | 3 | Motion sickness |
| 0 | 1 | 2 | 3 | Headache over eyes |
| 0 | 1 | 2 | 3 | Easily intoxicated |
| 0 | 1 | 2 | 3 | Hemorrhoids or varicose veins |
| 0 | 1 | 2 | 3 | Sensitivity to perfumes/chemicals/etc |
| 0 | 1 | 2 | 3 | Pain under right rib cage |
| 0 | 1 | 2 | 3 | Insomnia |
| Total: | | | | |

## Mineral Deficiencies:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Carpal Tunnel Syndrome |
| 0 | 1 | 2 | 3 | Osteoporosis or Osteopenia |
| 0 | 1 | 2 | 3 | Legs or foot cramps at rest |
| 0 | 1 | 2 | 3 | Pain or swelling in joints |
| 0 | 1 | 2 | 3 | Bursitis or tendonitis |
| 0 | 1 | 2 | 3 | Joints pop or crack |
| 0 | 1 | 2 | 3 | White spots on fingernails |
| 0 | 1 | 2 | 3 | Decreased taste or smell |
| Total: | | | | |

## Men’s Problems:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Prostate problems |
| 0 | 1 | 2 | 3 | Decreased libido |
| 0 | 1 | 2 | 3 | Urination difficult |
| 0 | 1 | 2 | 3 | Pain or burning with urination |
| 0 | 1 | 2 | 3 | Fatigue |
| 0 | 1 | 2 | 3 | Pain on inside of legs/heels |
| 0 | 1 | 2 | 3 | Feeling of incomplete bowel |
| Total: | | | | |

Please circle all that apply. Follow key below.
Key: 0=none symptom does not occur; 1=Yes, mild symptom, rarely occurs; 2=Moderate symptom, occurs weekly; 3=Severe symptom, occurs daily

## Women's Problems:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Painful menstrual cycle |
| 0 | 1 | 2 | 3 | Mood swings around cycle |
| 0 | 1 | 2 | 3 | Painful breasts at cycle |
| 0 | 1 | 2 | 3 | Irregular cycles |
| 0 | 1 | 2 | 3 | Heavy menstrual flow |
| 0 | 1 | 2 | 3 | Acne at menstrual cycle |
| 0 | 1 | 2 | 3 | Yeast infections |
| 0 | 1 | 2 | 3 | Endometriosis |
| 0 | 1 | 2 | 3 | Uterine fibroids |
| 0 | 1 | 2 | 3 | Fibrocystic breasts |
| 0 | 1 | 2 | 3 | Hot flashes |
| 0 | 1 | 2 | 3 | Vaginal itchiness |
| 0 | 1 | 2 | 3 | Vaginal discharge |
| 0 | 1 | 2 | 3 | Night sweats |
| 0 | 1 | 2 | 3 | Menopausal symptoms |
| Total: | | | | |

## Kidney and Bladder:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Pain upon urination |
| 0 | 1 | 2 | 3 | Frequent bladder infections |
| 0 | 1 | 2 | 3 | Cloudy, bloody, or dark urine |
| 0 | 1 | 2 | 3 | Urine has strong odor |
| 0 | 1 | 2 | 3 | History of kidney stones |
| 0 | 1 | 2 | 3 | Dribbling urination |
| 0 | 1 | 2 | 3 | Pain in lower back |
| Total: | | | | |

## Immune System:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Catch cold/flu easily |
| 0 | 1 | 2 | 3 | Runny or drippy nose |
| 0 | 1 | 2 | 3 | Swollen lymph nodes |
| 0 | 1 | 2 | 3 | Gets boils, cysts, stys |
| 0 | 1 | 2 | 3 | Poor wound healing |
| 0 | 1 | 2 | 3 | History of Epstein bar, mono, herpes, shingles, or chronic fatigue |
| Total: | | | | |

## Lyme Disease Traits:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Intense fatigue |
| 0 | 1 | 2 | 3 | Brain Fog |
| 0 | 1 | 2 | 3 | Memory loss-short/long term |
| 0 | 1 | 2 | 3 | Pain or swelling in joints |
| 0 | 1 | 2 | 3 | Stiff joints in morning |
| 0 | 1 | 2 | 3 | Muscle twitching |
| 0 | 1 | 2 | 3 | Unexplained fevers |
| 0 | 1 | 2 | 3 | Headaches/Migraines |
| 0 | 1 | 2 | 3 | Poor Concentration |
| 0 | 1 | 2 | 3 | Sore soles of feet in morning |
| Total: | | | | |

## Cardiovascular System:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Shortness of breath w/ moderate exertion |
| 0 | 1 | 2 | 3 | Opens windows in closed room |
| 0 | 1 | 2 | 3 | Sigh frequency |
| 0 | 1 | 2 | 3 | Bruise easily |
| 0 | 1 | 2 | 3 | Ankles swell at end of day |
| 0 | 1 | 2 | 3 | Muscle cramps during exercise |
| 0 | 1 | 2 | 3 | Hands and feet go to sleep |
| 0 | 1 | 2 | 3 | Dull pain in chest, worse on exertion |
| Total: | | | | |

## Vitamin Deficiencies:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Body jerks as falling asleep |
| 0 | 1 | 2 | 3 | Restless leg syndrome |
| 0 | 1 | 2 | 3 | Small bumps on back of arms |
| 0 | 1 | 2 | 3 | Heart races |
| 0 | 1 | 2 | 3 | Worrier/anxious |
| 0 | 1 | 2 | 3 | Nosebleeds |
| 0 | 1 | 2 | 3 | Bruise easily |
| 0 | 1 | 2 | 3 | Gums bleed easily |
| 0 | 1 | 2 | 3 | Depressed regularly |
| 0 | 1 | 2 | 3 | Numbness or tingling in body |
| 0 | 1 | 2 | 3 | Loss of muscle tone |
| Total: | | | | |

Please circle all that apply. Follow key below.
Key: 0=none symptom does not occur; 1=Yes, mild symptom, rarely occurs; 2=Moderate symptom, occurs weekly; 3=Severe symptom, occurs daily

## Adrenal Glands:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Difficulty falling asleep |
| 0 | 1 | 2 | 3 | Slow starter in the morning |
| 0 | 1 | 2 | 3 | Become dizzy when standing suddenly |
| 0 | 1 | 2 | 3 | Difficulty holding chiropractic adjustments |
| 0 | 1 | 2 | 3 | Arthritis |
| 0 | 1 | 2 | 3 | Crave salty foods |
| 0 | 1 | 2 | 3 | Headache after exercise |
| 0 | 1 | 2 | 3 | Chronic low back pain |
| 0 | 1 | 2 | 3 | Clench or grind teeth |
| 0 | 1 | 2 | 3 | Perspire too easily |
| 0 | 1 | 2 | 3 | Hives |
| 0 | 1 | 2 | 3 | Brightness hurts eyes |
| 0 | 1 | 2 | 3 | Slow recovery from stress |
| Total: | | | | |

## Thyroid Gland:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Difficulty losing weight |
| 0 | 1 | 2 | 3 | Loss of outer 1/3 eyebrows |
| 0 | 1 | 2 | 3 | Mentally Sluggish |
| 0 | 1 | 2 | 3 | Cold hands and feet |
| 0 | 1 | 2 | 3 | Hair loss |
| 0 | 1 | 2 | 3 | Easily fatigued |
| 0 | 1 | 2 | 3 | Seasonal sadness |
| 0 | 1 | 2 | 3 | Low body temperature |
| 0 | 1 | 2 | 3 | Sensitive to iodine |
| 0 | 1 | 2 | 3 | Fast pulse at rest |
| 0 | 1 | 2 | 3 | Nervousness |
| 0 | 1 | 2 | 3 | Sensitivity to cold |
| 0 | 1 | 2 | 3 | Intolerant to heat |
| 0 | 1 | 2 | 3 | Flush easily |
| 0 | 1 | 2 | 3 | Heart palpitations |
| Total: | | | | |

## Kidney and Bladder:

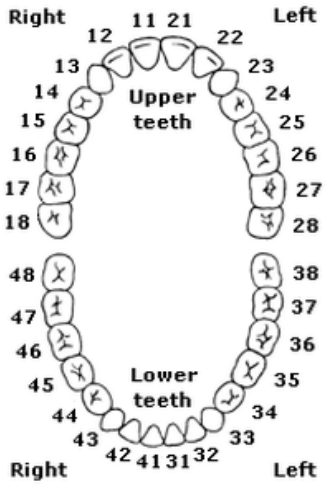
| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Pain upon urination |
| 0 | 1 | 2 | 3 | Frequent bladder infections |
| 0 | 1 | 2 | 3 | Cloudy, bloody, or dark urine |
| 0 | 1 | 2 | 3 | Urine has strong odor |
| 0 | 1 | 2 | 3 | History of kidney stones |
| 0 | 1 | 2 | 3 | Dribbling urination |
| 0 | 1 | 2 | 3 | Pain in lower back |
| Total: | | | | |

## Dental:

Do you have any metal fillings? If yes, which teeth

_____

Do you have any root canals? If yes, which teeth_____




## Blood Sugar Problems:

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | Crave sweets |
| 0 | 1 | 2 | 3 | Awaken during night, hard to fall back asleep |
| 0 | 1 | 2 | 3 | Excessive appetite |
| 0 | 1 | 2 | 3 | Crave coffee or sugar in afternoon |
| 0 | 1 | 2 | 3 | Headache if meals are delayed |
| 0 | 1 | 2 | 3 | Get shaky or weak if hungry |
| 0 | 1 | 2 | 3 | Sleepy in afternoon |
| 0 | 1 | 2 | 3 | Fatigue relieved by eating |
| 0 | 1 | 2 | 3 | Afternoon headaches |
| 0 | 1 | 2 | 3 | Irritable before meal |
| Total: | | | | |

## Diet:

| **Specific Food** | **How Much** | **Per Day-Week-Month** *circle one* |
|---|---|---|
| Coffee | Cups | Day Week Month |
| Soft Drinks | Can(s) | Day Week Month |
| Diet Soda | Can(s) | Day Week Month |
| Candy | Time(s) | Day Week Month |
| Chocolate | Time(s) | Day Week Month |
| Alcohol | Drink(s) | Day Week Month |
| Fast Food | Time(s) | Day Week Month |
| Milk/Cheese | Time(s) | Day Week Month |
| Fried Food | Time(s) | Day Week Month |
| Margarine/Tub Spreads | Time(s) | Day Week Month |

Current Diet: *Give average examples of your daily diet:*

| Breakfast: | Lunch: | Dinner: | Snacks: |
|---|---|---|---|
| | | | |

How many meals do you eat per day? _____
Do you skip any meals?_____ If so, which one(s)?
How often do you eat out? _____

*List some of your most common food items:*

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

**How serious are you about improving your health?** *Circle one.*
Very Serious Serious Other_____
**What are you willing to do to improve your health?** *Circle one.*
Take supplements Exercise WHATEVER IT TAKES!

**What are some ways you can reward yourself?**

_____

**What would have to happen for you to consider this program a success?**

_____