**Today's Date:**

| | | |
|---|---|---|
| Full Name: | | |
| Date of Birth: | Age: | Gender:<br>☐ Male<br>☐ Female<br>☐ Other |
| Contact No.: | | |
| Occupation: | Email: | |
| How did you hear about Integrative? | | |

| Main purpose/health complaints |
|---|
| |

| What is your level of stress each day? (from 1-10; 1 being very little stress, 10 being very high stress). Explain: |
|---|
| |
| How do you react to stress? |
| |

| What type of exercise do you do; how often? |
|---|
| |
| One a scale of 1 (low) to 10 (high) – how would you describe your energy levels during the day? |
| **Please specify any highs/lulls** |

| How many hours of sleep do you get each day? (Including naps) |
|---|
| |

| Please indicate, yes or no: | |
|---|---|
| Do you have trouble falling asleep? | ☐ Yes ☐ No |
| Do you have trouble staying asleep? | ☐ Yes ☐ No |
| Do you awake feeling rested? | ☐ Yes ☐ No |

| How many hours do you spend (on average)? | |
|---|---|
| Driving | Hrs. |
| Watching TV/on computer | Hrs. |
| Reading | Hrs. |

| Are you currently taking any medications? Please list name and reasons for each below. | ☐ Yes ☐ No |
|---|---|
| | |
| | |
| | |

| Are you currently taking any natural herbs, homeopathic remedies, vitamins/minerals? | ☐ Yes ☐ No |
|---|---|
| | |
| | |
| | |

| Do you take the birth control pill? Please indicate below. | ☐ Yes ☐ No |
|---|---|
| | |

| Have you taken antibiotics in the last 5 years? Please indicate below. | ☐ Yes ☐ No |
|---|---|
| | |

| Do you have any allergies or sensitivities? Please include reactions. | ☐ Yes ☐ No |
|---|---|
| | |
| | |
| | |

| Have you had surgery to remove your: | | |
|---|---|---|
| Gallbladder? | ☐ Yes | ☐ No |
| Tonsils? | ☐ Yes | ☐ No |
| Appendix? | ☐ Yes | ☐ No |

| How often do you have a bowel movement? | | |
|---|---|---|
| Do you strain to have a bowel movement? | ☐ Yes | ☐ No |
| Do you have loose bowel movements? | ☐ Yes | ☐ No |
| Is there undigested food in your stools? | ☐ Yes | ☐ No |

| Do you use recreational drugs (including marijuana)? Indicate type/how often: | ☐ Yes ☐ No ☐ Sometimes |
|---|---|
| | |

| Do you smoke cigarettes? | ☐ Yes ☐ No ☐ Sometimes |
|---|---|

| Does anyone you live or work with smoke cigarettes? | ☐ Yes ☐ No ☐ Sometimes |
|---|---|

| Do you drink alcohol? | ☐ Yes ☐ No ☐ Sometimes |
|---|---|

| Do you wish to change your weight? | ☐ Yes ☐ No ☐ Sometimes |
|---|---|
| How much would you like to gain or lose? (lbs.) | |

| What is your main motivation to lose/gain weight? Indicate below. |
|---|
| |

| FAMILY HISTORY *(Use 'F' for father; 'M' for mother; 'S' for sibling; 'G' for grandparent; 'O' for other)* | | | | | |
|---|---|---|---|---|---|
| | Allergies | | Diabetes | | Intestinal Disease |
| | Alcoholism | | Drug Abuse | | Mental Illness |
| | Arthritis | | Gall Bladder Issues | | Osteoporosis |
| | Asthma | | Heart Disease | | Skin Conditions |
| | Autoimmune Disease | | Hypertension | | Ulcers |
| | Cancer (type): | | Kidney Dysfunction | | Other: |

| Have you experienced fungal infections? (jock itch, athlete's foot) Describe: | ☐ Yes ☐ No |
|---|---|
| | |

| Have you experienced a decline in sexual interest? Describe: | ☐ Yes ☐ No |
|---|---|
| | |

| Have you had kidney or gall stones? | ☐ Yes ☐ No |
|---|---|

| FEMALES | | |
|---|---|---|
| Are you, or could you, be pregnant? | | ☐ Yes ☐ No |
| Have you noticed changes in menses? *(frequency, duration, clotting)* Describe. | ☐ Yes ☐ No ☐ Sometimes | |
| | | |
| Do you suffer from PMS symptoms? Describe. | ☐ Yes ☐ No ☐ Sometimes | |
| | | |
| Are you perimenopausal? | | ☐ Yes ☐ No |
| Are you menopausal? | | ☐ Yes ☐ No |

| MALES | | |
|---|---|---|
| Have you experienced any prostate problems? *(ie. frequent urination, discomfort during urination)* | ☐ Yes | ☐ No |
| If yes, please describe: | | |

| DIETARY HABITS *(provide examples of your typical meals)* | |
|---|---|
| Breakfast | |
| Lunch | |
| Dinner | |
| Snacks | |

| Do you feel that you are restricted with your diet due to the preferences of others, such as family, roommates, etc.? | ☐ Yes | ☐ No |
|---|---|---|

| Do you eat or use *(indicate '1' for rarely, '2' for regularly, '3' for often)?* | | | | | |
|---|---|---|---|---|---|
| | Albumin Pans | | Margarine | | Fast Food |
| | Microwave | | Fried Foods | | Alcohol |
| | Lunch Meats | | Cigarettes | | Candy |
| | Artificial Sweeteners | | Refined Foods *(pastries)* | | |

| Please indicate how many cups of the following you drink **per day**: | | | | | |
|---|---|---|---|---|---|
| | Tap Water | | Milk (dairy) | | Bottled or Spring Water |
| | Coffee | | Non-dairy Milk | | Herbal Tea |
| | Tea | | Prepared Vegetable Juices | | Fresh Fruit Juices |
| | Soft Drinks | | Fresh Vegetable Juices | | Fruit Juices |
| | Red Wine | | White Wine | | Beer |
| | Other Alcoholic Beverages | | | | |

| Are you a… | ☐ Meat Eater | ☐ Vegetarian | ☐ Vegan | ☐ Other: |
|---|---|---|---|---|

| How often do you eat meat? | ☐ Daily | ☐ 3-5x/week | ☐ 1/week or less |
|---|---|---|---|

| How often do you consume dairy products? | ☐ Daily | ☐ 3-5x/week | ☐ 1/week or less |
|---|---|---|---|

| What are your favorite foods? | | |
|---|---|---|
| | | |
| | | |

| How often do you eat your favorite foods? | ☐ Daily ☐ 3-5x/week ☐ 1/week or less |
|---|---|

| Which food(s) do you crave? | How often do you eat them? |
|---|---|
| | |
| | |
| | |
| | |

| Do you avoid certain foods? Please explain: | ☐ Yes ☐ No |
|---|---|
| | |

| Do you experience any symptoms if: | |
|---|---|
| Meals are missed? Please explain: | ☐ Yes ☐ No |
| | |
| After a meal? Please explain: | ☐ Yes ☐ No |
| | |

| Is there anything else pertaining your health and dietary lifestyle that you feel is important? |
|---|
| |

## CLIENT DECLARATION

I understand and acknowledge 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 statement is being signed voluntarily.

| |
|---|
| Signature |

| NAME *(Please Print)* | |
|---|---|
| DATE SIGNED | |