BioIntelligent Wellness

INITIAL CONSULTATION CLIENT INTAKE FORM

I. Personal Information

Name* **Birth Date**

Address*

City* **State*** **Zip***

Occupation

Phone* **Email***

Height: ____Feet ____ Inches **Weight: ____pounds** **Dominant Wrist: ____inches**

Sex:
☐ M ☐ F

Blood Type:
☐ A ☐ B ☐ AB ☐ O

Activity Level:
___ Sedentary (little or no exercise, desk job or bed ridden)
___ Light Activity (light exercise – sports 1-3 days per week)
___ Moderate Activity (moderate ex.: sports 3-5 days/week)
___ Very Active (hard exercise – sports 6-7 days per week)
___ Extra Active (hard daily exercise – sports and physical job)

Goals:
☐ Look Better
☐ Feel Better
☐ Perform Better

RH Factor:
☐ + ☐ -

Food Component Reactions Toxins and Junk Food

___ Amines ___ Salicylates ___ Alcohol ___ Non-food Items (synthetics) ___ Citrus Fruits
___ Caffeine ___ Soy ___ Yeast ___ Dairy (casein & lactose) ___ Carcinogens & Toxins
___ Eggs ___ Refined sugars ___ Sulfites ___ Fluoride/Chlorine ___ Glutamates
___ Shellfish ___ Harmful Fats ___ Theobromine ___ Gluten & Gliadin ___ Pesticides (for organic diets)
___ Mercury Contaminated Foods

Ethnic & Vegetarian Intolerances (check to remove from diet)

___ Red Meat ___ Dairy Foods ___Eggs and Egg Products ___Fish and Seafood ___ Poultry
___Non-Hindu Foods ___ Non-Kosher Foods ___Non-Muslim Foods

1. **What is your main health concern?**

2. **What drew you to nutritional counseling?**

3. **What is keeping you from optimal health?**

4. **In what way could it all be better?**

5. **What has worked for you in the past?**

6. **What changed?**

7. **Do you have any specific cravings?**
    a) **When do you crave that?**
    b) **How often?**
    c) **How does it make you feel?**
    d) **Does it make you feel better or worse?**

8. **In your relationship to food and health, where do you get confused?**

9. **What is your stress level on a scale of 1-10?**

10. **How does stress affect your relationship to food?**

11. **How does it manifest in your body?**

12. **What do you do to pamper yourself, unwind? How often?**

13. **Is there anything that you'd like to be doing for yourself that you're not?**

14. What gets in the way of doing these things?

15. How would you feel if you were doing this thing on a regular basis?

16. Where would like to see your health in 3 months, 6 months, 1 year?

17. What nutritional supplements are you currently taking?

18. What prescription medications are you currently taking?

19. What are your 3 BIGGEST obstacles to being in your peak health?

20. What is the ONE thing you could be doing for yourself that you know would have a significant impact on your health and well-being?

21. What questions or topics would you MOST like to know more about?

Let's Get An Idea of Where You're At and What You've Been Doing:

Nutrition	Your Idea of a "GOOD" Day	Your Idea of a "BAD" Day	A Typical Day
Breakfast			
Snack 1			
Lunch			
Snack 2			
Dinner			
Snack 3/ Dessert			
Water (ounces)			
Total Calories: Even if you have to guess			
Exercise	**Your Idea of a "GOOD" Day**	**Your Idea of a "BAD" Day**	**A Typical Day**
Health & Lifestyle	**Your Idea of a "GOOD" Day**	**Your Idea of a "BAD" Day**	**A Typical Day**
Stress Level (1-10 low to high)			
Sleep (hrs)			
Hours Working (hrs)			
Self Care			
Leisure Activity/Hobby			
Relaxation			

II. Body Systems Questionnaire - Please select every symptom that you experience.

- ☐ Abdominal pain or discomfort
- ☐ Absent-mindedness or forgetfulness
- ☐ Acid indigestion or heartburn
- ☐ Anxiety, nervousness or tension
- ☐ Asthma
- ☐ Bad breath or body odor
- ☐ Brittle fingernails
- ☐ Burning or painful urination
- ☐ Cold hands and feet
- ☐ Colitis or other bowel irritations
- ☐ Congested air passages
- ☐ Constipation or dry stools
- ☐ Cravings for fat or high fat diet
- ☐ Cravings for sugar
- ☐ Dark circles or puffiness under eyes
- ☐ Difficulty getting to sleep
- ☐ Dizziness or light headedness
- ☐ Dry Skin
- ☐ Excess mucus production
- ☐ Family history of heart disease
- ☐ Fatigue in the afternoons
- ☐ Fatigue or low energy levels
- ☐ Food allergies
- ☐ Food sits heavy on stomach after eating
- ☐ Frequent backache
- ☐ Frequent cough
- ☐ Frequent infections
- ☐ Frequent urinary tract infections
- ☐ General weakness or chronic illness
- ☐ Hayfever
- ☐ Heart problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Impotency (males only)
- ☐ Infertility
- ☐ Intestinal gas or bloating
- ☐ Itchy nose and ears
- ☐ Joint pain, arthritis or gout
- ☐ Leg cramps or pains
- ☐ Less than 1 bowel elimination per day
- ☐ Loose stool or diarrhea
- ☐ Loss of appetite or poor appetite
- ☐ Loss of sexual desire
- ☐ Menopause problems (females)
- ☐ Menstrual problems (females)
- ☐ Mental / emotional stress
- ☐ Migraine headaches
- ☐ Muddled thinking, confusion or mental sluggishness
- ☐ Osteoporosis
- ☐ Pale complexion and/or anemia
- ☐ Prostate problems (males)
- ☐ Restless dreams or nightmares
- ☐ Scant or excessive urination
- ☐ Sinus congestion
- ☐ Sinus headaches
- ☐ Skin problems (acne, rashes, etc.)
- ☐ Stiff, aching, or painful muscles
- ☐ Swollen lymph glands
- ☐ Ulcers
- ☐ Underweight or unable to gain weight
- ☐ Urinating at night
- ☐ Varicose veins
- ☐ Waking up frequently at night
- ☐ Water retention or edema
- ☐ Weak legs, knees or ankles
- ☐ Wheezing or shortness or breath
- ☐ Wounds won't heal on extremities, i.e. arms, hands, legs, feet

Conditions and Complaints

-- SELECT ONLY THE MOST SIGNIFICANT ISSUES AND HIGHLIGHT THE SINGLE WORST PROBLEM --

__ Acne (vulgaris)
__ Adrenal Hyper-function
__ Adrenal Hypo-function
__ AIDS or HIV
__ Alcoholism
__ Alzheimer's Disease
__ Amenorrhea
__ Anemia (macro & microcytic)
__ Angina Pectoris
__ Anxiety
__ Appetite Excessive
__ Appetite Reduced
__ Arteriosclerosis
__ Asthma
__ Atherosclerosis
__ Attention Deficit Disorder
__ Autism
__ Bell's Palsy
__ Benign Prostatic Hyperplasia
__ Biliary Insufficiency
__ Biliary Stasis
__ Bipolar Disorder
__ Bleeding Gums
__ Body Odor
__ Bone Spurs
__ Bradycardia
__ Bronchitis
__ Bruxism
__ Burning Feet
__ Burns (1st, 2nd, 3rd degree)
__ Bursitis
__ Cancer (prevention)
__ Canker Sores
__ Cardiac Arrhythmia
__ Cataracts
__ Celiac Disease (sprue)
__ Chemotherapy Support
__ Cervical Dysplasia
__ Chicken Pox
__ Cholesterol Decreased (total)
__ Cholesterol Elevated (total)
__ Chronic Fatigue Syndrome
__ Colic (mother's & child's diet)
__ Congestive Heart Failure
__ Constipation
__ COPD
__ Copper toxicity
__ Coronary Artery Disease
__ Crohn's Disease
__ Cystic Fibrosis
__ Cytomegalovirus (CMV)
__ Degenerative Joint Disease
__ Dental Caries (cavities)
__ Depression
__ Dermatitis
__ Detoxification Support
__ Diabetes (type I)
__ Diabetes (type II)
__ Diarrhea
__ Diverticulosis
__ Drug Addiction
__ Dry Eyes (Sjögren's synd.)
__ Dry Skin
__ Dysmenorrhea
__ Dyspepsia (indigestion)
__ Ear Infections
__ Eczema
__ Edema
__ Emphysema
__ Endometriosis
__ Enuresis (bed wetting)
__ Epilepsy (seizure disorders)
__ Epstein Barr Virus (EBV)
__ Fever
__ Fibrocystic Breast Disease
__ Fibromyalgia
__ Flatulence
__ Fractures
__ Gallbladder Dysfunction
__ Gallstones
__ GERD
__ Glaucoma
__ Goiter
__ Gout
__ Grave's Disease
__ Halitosis
__ Hashimoto's Disease
__ Headaches (non-migraine)
__ Heal Spurs
__ Heavy Metal Toxicity
__ Hemachromatosis
__ Hemophilia
__ Hemorrhoids
__ Hepatic Cirrhosis
__ Hepatic Disease Support
__ Hepatitis
__ Herpes Simplex (HSV-1)
__ Herpes Zoster (HSV-2)
__ Hiatal Hernia
__ High Cholesterol (LDL)
__ High Triglycerides
__ Homocysteine Elevated
__ Hot Flashes (menopausal)
__ Hyperglycemia
__ Hyperkinesis
__ Hypertension
__ Hyperthyroidism
__ Hypochlorhydria
__ Hypoglycemia
__ Hypotension
__ Hypothyroidism
__ Idiopathic Thrombo. Purpura
__ Ileitis
__ Ileocecal Valve Dysfunction
__ Immune Deficiency
__ Impotence (male)
__ Incontinence
__ Infection (bacterial)
__ Infection (parasitic)
__ Infection (prostate)
__ Infection (respiratory)
__ Infection (sinus)
__ Infection (urinary)
__ Infection (viral)
__ Infection (yeast/fungal)
__ Infertility (female)
__ Infertility (male)
__ Inflammation (general)
__ Inflammation (vascular)
__ Influenza (flu)
__ Insomnia
__ Interstitial Cystitis
__ Irritable Bowel Syndrome
__ Joint Pain
__ Kidney Stones
__ Lactose Intolerance
__ Liver-Colon Detoxification
__ Low Cholesterol (HDL)
__ Lung Problems (non-specific)
__ Lupus
__ Lyme Disease
__ Macular Degeneration
__ Manic Depression
__ Measles
__ Meniere's Disease
__ Menorrhagia
__ Menstrual Cramps
__ Metabolic Syndrome
__ Migraine Headache
__ Mitral Valve Prolapse
__ Mononucleosis
__ Mucous (allergy related)
__ Mucous (respiratory/sinus)
__ Multiple Sclerosis (MS)
__ Mumps
__ Muscular Dystrophy
__ Myasthenia Gravis
__ Nausea
__ Nausea (during pregnancy)
__ Obesity
__ Osteoarthritis
__ Osteoporosis
__ Pain (musculoskeletal)
__ Pancreatitis
__ Panic Disorder
__ Parasthesia
__ Parkinson's Disease
__ PCOS
__ Peptic/Duodenal Ulcer
__ Periodontal Disease
__ Phlebitis
__ Phobias
__ Pituitary Dysfunction
__ PMS
__ Pneumonia
__ Polycythemia (secondary)
__ Pregnancy (gen. support)
__ Pregnancy & Yeast Infec.
__ Psoriasis
__ Purpura Simplex
__ Radiation Therapy Support
__ Raynaud's Disease
__ Reduced Circulation
__ Rhinovirus (common cold)
__ Rheumatoid Arthritis
__ Rhinovirus (comm.cold)
__ Schizophrenia
__ Sciatica
__ Scleroderma
__ Seborrhea
__ Sex Drive Diminished (F)
__ Sex Drive Diminished (M)
__ Skin Rashes
__ Sperm Count Reduced
__ Stroke (recovery support)
__ Sulfite Allergy-Sensitivity
__ Surgery Support (pre/ post)
__ Tachycardia
__ Tendonitis
__ Thrombophlebitis
__ Tinea (ringworm)
__ Tinnitus
__ Trigeminal Neuralgia
__ Tuberculosis (TB)
__ Ulcerative Colitis
__ Urticaria (hives)
__ Uterine Fibroids
__ Varicose Veins
__ Vertigo
__ Vitiligo
__ Wilson's Syndrome
__ Xerophthalmia

History & Symptoms Questionnaire:

Follow the instructions of each section. At the end, total up your scores for each section and enter below.

Section 1: **Section 2:** **Section 3:** **Section 4:**

Section 5: **Section 6:** **Section 7:** **Section 8:**

This questionnaire is a quick way to identify many root causes of clinical conditions. As a nutritionist, I use this as a springboard into developing an individualized action plan. It also helps prioritize health issues, so that I can work effectively with each client. **For each section, highlight the number on the left for answers that apply to you, add the total and place it in the total score line provided for that section. When you finish all sections, record your totals in the answer key above:**

Section 1. Score _____

4 Sensitivity to emotional (or physical) pain; cry easily	4 Inability to relax after tension, stress
4 Eat as a reward for pleasure, comfort, numbness	3 Depression, negativity
4 Worry, anxiety, phobia or panic	4 Low self-esteem, lack of confidence
4 Difficulty getting to sleep or staying asleep	4 More mood and eating problems in winter or end of day
3 Difficulty with focus, attention deficits	3 Irritability, anger
2 Low energy, drive and arousal	4 Use alcohol or drugs to improve mood
4 Obsessive thinking or behavior	

Section 2. Score _____

4 Increased cravings for and focus on food; overeating	2 Use aspartame daily
4 Regain weight after dieting, more than was lost	2 Take Prozac or similar serotonin-boosting drugs
3 Increased moodiness, irritability, anxiety, or depression	2 Have become vegetarian
3 Less energy and endurance	3 Decreased self-esteem
3 Usually eat less than 2,100 calories/day	4 Have become bulimic or anorectic
3 Skip meals, especially breakfast	
3 Eat mostly low-fat carbs like bagels and pasta	
2 Constantly think about weight	

Section 3. Total Score _____

4 Crave a lift from sweets or alcohol, but experience a drop in mood afterwards	5 Light-headed, especially on standing up
4 Family history of diabetes, hypoglycemia, or alcoholism	4 Crave salty foods or licorice
3 Nervous, jittery, irritable, headachy or weak, on and off during the day. May be calmer after meals	4 Often feel stressed, overwhelmed and exhausted
3 Frequent infections, allergies or asthma, especially when weather changes	4 Dark circles under eyes or eyes sensitive to bright ligh
3 Mental confusion, decreased memory, hard to focus or get organized	4 More awake at night
4 Frequent thirst	
3 Night sweats (not menopausal)	

Section 4. Total Score _____

4 Low energy 4 Easily chilled (especially hands and feet) 4 Other family members have thyroid problems 4 Can gain weight without overeating; hard to lose excess weight 3 Have to force yourself to do even moderate exercise 4 Find it hard to get going in the morning	3 High cholesterol 3 Low blood pressure 4 Weight gain began near the start of menses, a pregnancy, or menopause 3 Chronic headaches 3 Use food, caffeine, tobacco and /or other stimulants to get going

Section 5. Total Score _____

4 Premenstrual mood swings 4 Premenstrual or menopausal food cravings 4 Irregular periods or migraines 4 History of fibroids 3 Experienced miscarriage, abortion or infertility	4 Use(d) birth control pills or other hormone medication 3 Uncomfortable periods – cramps, lengthy or heavy bleeding, or sore breasts 4 Peri- or postmenopausal discomfort (hot flashes, weight gains, sweats, insomnia or mental dullness) 3 Skin eruptions with period

Section 6. Total Score _____

3 Crave milk, ice cream, yogurt, cheese, or doughy foods and eat them frequently 3 Experience bloating after meals 4 Gas, frequent belching 3 Digestive discomfort of any kind 3 Chronic constipation and/or diarrhea 4 Respiratory problems, such as asthma, postnasal drip, congestion 3 Low energy or drowsiness, especially after meals 4 Allergic to milk products or other common foods	3 Under-eat or often prefer beverages to solid foods 3 Avoid food or throw up food because bloating after eating makes you feel fat or tired 4 Can't gain weight 3 Hyperactivity or manic depression 3 Severe headaches or migraine 4 Food allergies in family

Section 7. Total Score _____

3 Crave milk, ice cream, yogurt, cheese, or doughy foods and eat them frequently 3 Experience bloating after meals 4 Gas, frequent belching 3 Digestive discomfort of any kind 3 Chronic constipation and/or diarrhea 4 Respiratory problems, such as asthma, postnasal drip, congestion 3 Low energy or drowsiness, especially after meals 4 Allergic to milk products or other common foods 3 Stool unusual in color, shape or consistency	4 Often bloated abdominal distention 3 Foggy-headed 2 Depressed 4 Yeast Infections 4 Used antibiotics extensively (at any time in life) 4 Used cortisone or birth control pills for more than one year 4 Have chronic fungus on nails or skin or athlete's foot 3 Recurring sinus or ear infections as an adult or child 3 Achy muscles and joints 4 Rashes

Section 8. Total Score _____

3 Crave milk, ice cream, yogurt, cheese, or doughy foods and eat them frequently 3 Experience bloating after meals 4 Crave chips, cheese, and other rich foods more than, or in addition to sweets and starches 4 Have ancestry that includes Irish, Scottish, Welsh, Scandinavian or coastal Native American 3 Alcoholism and depression in the family history 3 High cholesterol, low HDL levels 4 Feel heavy, uncomfortable, and "clogged up" after eating fatty foods	4 Often bloated abdominal distention 3 Foggy-headed 2 Depressed 4 History of hepatitis or other liver or gallbladder problems 4 Light colored stools 4 Hard or foul-smelling stool 4 Pain on right side under rib cage

Comments: