BioIntelligent Wellness

Phone: 858 228 3644
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www.BioIntelligentWellness.com

Solana Beach
124 Lomas Santa Fe, Suite 206
Solana Beach CA 92075

Carlsbad
7220 Avenida Encinas, Suite 110-B,
Carlsbad, CA 92011

Initial Consultation Client Intake Form

Personal Information

Please use print characters

Full Name ____________________

Date of Birth ____________________

Age ____________________

Address ____________________

Zip/Postal Code ____________________

City ____________________

State ____________________

Referred by ____________________

E-mail ____________________

Phone ____________________

Cell ____________________

Occupation ____________________

☐ Male ☐ Female

Current Weight (inch) ____________________

Height (cm) ____________________

Dominant Wrist (inch) ____________________

Blood Type (A / B / AB / 0) and RH Factor (+ -) ____________________

My goal is to

- ☐ Look better
- ☐ Feel better
- ☐ Perform better

Activity Level

- ☐ Sedentary
  (little or no exercise, desk job or bed ridden
- ☐ Light Activity
  little or no exercise, desk job or bed ridden
- ☐ 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

Food Components I Avoid

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

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

Let's Talk

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?

☐ **I have cravings**

☐ **I have some specific cravings**

When do you crave that?

How often?

How does it make you feel?

Does it make you feel better or worse?

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

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

9. How does stress affect your relationship to food?

10. How does it manifest in your body?

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

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

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

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

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

16. What nutritional supplements are you currently taking?

17. What prescription medications are you currently taking?

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

19. 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?

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

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Nutrition

	Your Idea of a "GOOD" Day	Your Idea of a "BAD" Day	A Typical Day
Breakfast			
Snack before Lunch			
Lunch			
Snack before dinner			
Dinner			
Snack at night (desert)			
Water (ounces)			
Total Calories: Even if you have to guess			

Exercise

Exercise Name	Your Idea of a "GOOD" Day	Your Idea of a "BAD" Day	A Typical Day

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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			

Body Systems Questionnaire

Please select every symptom that you experience

Section 1

- ☐ 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

Section 2

- ☐ Excess mucus production
- ☐ Family history of heart disease
- ☐ Fatigue in the afternoons
- ☐ Frequent urinary tract infections
- ☐ General weakness or chronic illness
- ☐ Hayfever

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Section 3

- ☐ Fatigue or low energy levels
- ☐ Food allergies
- ☐ Food sits heavy on stomach after eating
- ☐ Frequent backache
- ☐ Frequent cough
- ☐ Frequent infections
- ☐ Joint pain, arthritis or gout
- ☐ Leg cramps or pains
- ☐ Less than 1 bowel elimination per day
- ☐ Loose stool or diarrhea
- ☐ Heart problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Impotency (males only)
- ☐ Infertility
- ☐ Intestinal gas or bloating
- ☐ Itchy nose and ears
- ☐ Mental / emotional stress
- ☐ Migraine headaches
- ☐ Muddled thinking, confusion or mental sluggishness

Section 4

- ☐ Loss of appetite or poor appetiteafter
- ☐ Loss of sexual desire
- ☐ Menopause problems (females)
- ☐ Menstrual problems (females)
- ☐ Sinus congestion
- ☐ Sinus headaches
- ☐ Skin problems (acne, rashes, etc.)
- ☐ Ulcers
- ☐ Underweight or unable to gain weight
- ☐ Urinating at night
- ☐ Varicose veins
- ☐ Waking up frequently at night
- ☐ Osteoporosis
- ☐ Pale complexion and/or anemia
- ☐ Prostate problems (males)
- ☐ Restless dreams or nightmares
- ☐ Scant or excessive urination
- ☐ Stiff, aching, or painful muscles
- ☐ Swollen lymph glands
- ☐ 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

Please select all that apply

Section 1

- ☐ Acne (vulgaris)
- ☐ Adrenal Hyper-function
- ☐ Adrenal Hypo-function
- ☐ AIDS or HIV
- ☐ Appetite Excessive
- ☐ Appetite Reduced
- ☐ Arteriosclerosis
- ☐ Asthma

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- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anemia (macro & microcytic)
- ☐ Angina Pectoris
- ☐ Anxiety
- ☐ Atherosclerosis
- ☐ Attention Deficit Disorder
- ☐ Autism
- ☐ Bell's Palsy
- ☐ Benign Prostatic Hyperplasia

Section 2

- ☐ Biliary Insufficiency
- ☐ Biliary Stasi
- ☐ Bipolar Disorder
- ☐ Bleeding Gums
- ☐ Body Odor
- ☐ Bone Spurs
- ☐ Bradycardia
- ☐ Cardiac Arrhythmi
- ☐ Cataracts
- ☐ Bronchitis
- ☐ Bruxism
- ☐ Burning Feet
- ☐ Burns (1st, 2nd, 3rd degree)
- ☐ Bursitis
- ☐ Cancer (prevention)
- ☐ Canker Sores
- ☐ Celiac Disease (sprue)
- ☐ Chemotherapy Support

Section 3

- ☐ 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
- ☐ Cystic Fibrosis
- ☐ Cytomegalovirus (CMV)
- ☐ Degenerative Joint Disease
- ☐ Dental Caries (cavities)
- ☐ Depression
- ☐ Dermatitis
- ☐ Detoxification Support

Section 4

- ☐ Diabetes (type I)
- ☐ Diabetes (type II)
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Drug Addiction
- ☐ Dry Eyes (Sjögren's synd.)
- ☐ Dry Skin
- ☐ Ear Infections
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Enuresis (bed wetting)
- ☐ Epilepsy (seizure disorders)

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- ☐ Dysmenorrhea
- ☐ Dyspepsia (indigestion)
- ☐ Fibrocystic Breast Disease
- ☐ Fibromyalgia
- ☐ Gallbladder Dysfunction
- ☐ Gallstones
- ☐ GERD
- ☐ Glaucoma
- ☐ Goiter
- ☐ Epstein Barr Virus (EBV)
- ☐ Fever
- ☐ Flatulence
- ☐ Fractures
- ☐ Gout
- ☐ Grave's Disease
- ☐ Halitosis
- ☐ Hashimoto's Disease
- ☐ Headaches (non-migraine)

Section 5

- ☐ 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

Section 6

- ☐ Hyperthyroidism
- ☐ Hypochlorhydria
- ☐ Hypoglycemia
- ☐ Hypotension
- ☐ Hypothyroidism
- ☐ Impotence (male)
- ☐ Incontinence
- ☐ Idiopathic Thrombo. Purpura
- ☐ Ileitis
- ☐ Ileocecal Valve Dysfunction

Infection

- ☐ Bacterial
- ☐ Parasitic
- ☐ Prostate
- ☐ Respiratory
- ☐ Sinus
- ☐ Urinary
- ☐ Viral
- ☐ Yeast/fungal

- ☐ Infertility
- ☐ Inflammation (general)
- ☐ Insomnia
- ☐ Interstitial Cystitis
- ☐ Inflammation (vascular)
- ☐ Influenza (flu)
- ☐ Lupus
- ☐ Lyme Disease

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- ☐ Irritable Bowel Syndrome
- ☐ Joint Pain
- ☐ Kidney Stones
- ☐ Lactose Intolerance
- ☐ Liver-Colon Detoxification
- ☐ Low Cholesterol (HDL)
- ☐ Lung Problems (non-specific)
- ☐ Macular Degeneration
- ☐ Manic Depression
- ☐ Measles
- ☐ Meniere's Disease
- ☐ Menorrhagia
- ☐ Menstrual Cramps
- ☐ Metabolic Syndrome

Section 7

- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Mucous (allergy related)
- ☐ Mucous (respiratory/sinus)
- ☐ Multiple Sclerosis (MS)
- ☐ Mumps
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ PCOS
- ☐ Peptic/Duodenal Ulcer
- ☐ Nausea
- ☐ Nausea (during pregnancy)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pain (musculoskeletal)
- ☐ Pancreatitis
- ☐ Panic Disorder
- ☐ Parasthesia
- ☐ Parkinson's Disease
- ☐ Periodontal Disease
- ☐ Phlebitis

Section 8

- ☐ Phobias
- ☐ Pituitary Dysfunction
- ☐ PMS
- ☐ Pneumonia
- ☐ Polycythemia (secondary)
- ☐ Raynaud's Disease
- ☐ Reduced Circulation
- ☐ Rhinovirus (common cold)
- ☐ Rheumatoid Arthritis
- ☐ Rhinovirus (comm.cold)
- ☐ Schizophrenia
- ☐ Sciatica
- ☐ Scleroderma
- ☐ Seborrhea
- ☐ Pregnancy (gen. support)
- ☐ Pregnancy & Yeast Infec.
- ☐ Psoriasis
- ☐ Purpura Simplex
- ☐ Radiation Therapy Support
- ☐ Sex Drive Diminished
- ☐ Skin Rashes
- ☐ Sperm Count Reduced
- ☐ Stroke (recovery support)
- ☐ Sulfite Allergy-Sensitivity
- ☐ Surgery Support (pre/ post)
- ☐ Tachycardia
- ☐ Tendonitis
- ☐ Thrombophlebitis

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- [ ] Tinea (ringworm)
- [ ] Tinnitus
- [ ] Trigeminal Neuralgia
- [ ] Tuberculosis (TB)
- [ ] Ulcerative Colitis
- [ ] Urticaria (hives)
- [ ] Immune Deficiency
- [ ] Uterine Fibroids
- [ ] Varicose Veins
- [ ] Vertigo
- [ ] Vitiligo
- [ ] Wilson's Syndrome
- [ ] Xerophthalmia

History & Symptoms Questionnaire

Follow the instructions of each section.

Why Needed

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.

Instruction

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

4 Sensitivity to emotional (or physical) pain; cry easily

4 Eat as a reward for pleasure, comfort, numbness

4 Worry, anxiety, phobia or panic

4 Difficulty getting to sleep or staying asleep

3 Difficulty with focus, attention deficits

2 Low energy, drive and arousal

4 Obsessive thinking or behavior

4 Inability to relax after tension, stress

3 Depression, negativity

4 Low self-esteem, lack of confidence

4 More mood and eating problems in winter or end of day

3 Irritability, anger

4 Use alcohol or drugs to improve mood

Your Score: ___________

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Section 2

4 Increased cravings for and focus on food; overeating

4 Regain weight after dieting, more than was lost

3 Increased moodiness, irritability, anxiety, or depression

3 Less energy and endurance

3 Usually eat less than 2,100 calories/day

3 Skip meals, especially breakfast

3 Eat mostly low-fat carbs like bagels and pasta

2 Constantly think about weight

2 Use aspartame daily

2 Take Prozac or similar serotonin-boosting drugs

2 Have become vegetarian

3 Decreased self-esteem

4 Have become bulimic or anorectic

Your Score: ___________

Section 3

4 Crave a lift from sweets or alcohol, but experience a drop in mood afterwards

4 Family history of diabetes, hypoglycemia, or alcoholism

3 Nervous, jittery, irritable, headachy or weak, on and off during the day. May be calmer after meals

3 Frequent infections, allergies or asthma, especially when weather changes

3 Mental confusion, decreased memory, hard to focus or get organized

4 Frequent thirst

3 Night sweats (not menopausal)

5 Light-headed, especially on standing up

4 Crave salty foods or licorice

4 Often feel stressed, overwhelmed and exhausted

4 Dark circles under eyes or eyes sensitive to bright ligh

4 More awake at night

Your Score: ___________

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Section 4

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

Your Score: __________

Section 5

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 Low blood pressure

3 Uncomfortable periods – cramps, lengthy or heavy bleeding, or sore breasts

3 Skin eruptions with period

4 Peri- or postmenopausal discomfort (hot flashes, weight gains, sweats, insomnia or mental dullness)

Your Score: __________

Section 6

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

Your Score: __________

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Section 7

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

Your Score: ________

Section 8

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

3 Chronic constipation and/or diarrhea

4 Have ancestry that includes Irish, Scottish, Welsh, Scandinavian or 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

Your Score: ________

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Please, write down your score for each section here

1 Section: ________ **3 Section:** ________ **5 Section:** ________ **7 Section:** ________

2 Section: ________ **4 Section:** ________ **6 Section:** ________ **8 Section:** ________

Your Comments

____

____

____

____

____

____

____

____

____

____

____