# Health Evaluation Intake Form

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Name: Date:

Address: City: State: Zip:

Phone: Email:

Birthdate: Height: Weight:

Your household consists of:

Occupation:

☐ Check here to receive nourishing wellness tips!

How did you hear about me?

☐ Yelp ☐ Google Search ☐ Referred by: __________________ ☐ Other: ______

## Health Concerns:

What are your health concerns? Describe all concerns in detail.

How have you dealt with these concerns in the past (doctors, self-care, diets)?

What other health practitioners are you currently seeing?

List any medicine or supplements you are taking and their purpose:

Have any family members had similar issues? Do your family members have other health issues?

Does stress make your health concerns worse?

How is your sleep: Can you get to sleep easily? Can you stay asleep?

For women: How are/were your cycles? Do/did you have PMS? Painful periods? If menopausal, please list symptoms.

How often do you have a bowel movement?

How are your moods in general?

Do you have any cravings? (Certain foods, caffeine, alcohol etc.)

Where do you shop for food?

On a scale of 1-10 — 1 being low and 10 being high — what is your usual level of energy?

What are your health goals?