Client Intake Form

Name:_____ Date: _____

Address:_____

City:_____State:_____Zip:_____Telephone:_____

Occupation_____

Age_____ Height _____ Weight_____

Marital Status: __Single __Married __Divorced __Separated __Widowed

# of Children___ Ages_____Head of Household_____

Birthdate_____Place_____Time_____

Please describe your primary health concern and related symptoms:

_____
_____
_____
_____

Please describe your secondary health concern and related symptoms:

_____
_____
_____

Please describe any additional health concerns and related symptoms:

_____
_____
_____

Please list major past illness, surgeries or injuries

_____
_____
_____

Please list major illnesses that run in your family or they currently have.
Father:_____
Mother:_____
Siblings:_____

List current medications (pharmaceuticals, pain relievers, herbal medicines, supplements)

_____
_____
_____
_____

Diet: Foods generally eaten (write # of times eaten per week)

___Meat (beef, pork, lamb)
___Fowl (chicken, turkey)
___Eggs
___Sea Food (fish, shellfish)
___Oil/Butter/Margarine/Ghee
___Fast Foods Take-out
___ Raw Food
___Milk
___Sweets/Deserts
___Whole Grains
Specify_____
___Yogurt
___Cheese
___Ice Cream
___Crackers

___Salsa
___Chips
___Chilies
___Hot Sauce
___Bread
___Pasta
___Rice
___Sugar
___Soft Drinks
___Coffee/Tea
___Alcohol/Wine
Beer
___Artificial Sweeteners
___Honey
___Juices

Vegetables
(Specify top 10 x / week)
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Fruit
(Specify top 10 x / week)
_____ ____
_____ ____
_____ ____
_____ ____
_____ ____
_____ ____
_____ ____
_____ ____
_____ ____
_____ ____

Food allergies

___Gluten
___Dairy
___Soy
___Nuts
___Other
Please describe: _____

Please indicate which symptoms you are currently experiencing:

Air

Nervous System

___Difficulty falling asleep
___Anxiety
___Dizziness/Lightheaded
___Shaking/Tremors
___Fatigue
___Pain/Spasms
___Numbness/Tingling
___ Ringing in Ears
___Difficulty staying asleep

Respiratory System

___Painful Breathing
___Shortness of Breath w/ exertion
___Asthma
___Dry cough
___Earaches
___Wheezing
___Frequent chest cold/lung infection
___Sinus infection

Fire

___Headache/Migraine
___Eye Strain
___Vision is deteriorating
___Thinning/Hair Loss
___Stress/overworked
___Forgetful/Memory Loss
___PTSD
___Loss of balance

Water/Earth

___Groggy upon waking
___Depression
___Poor concentration/ unclear thinking
___Loss of smell
___Loss of taste
___Congestion/mucus
___Wet cough
___Sore throat
___Seasonal allerg

Digestive System: How many bowel movements do you have per day? _____

___Gas and Bloating
___Constipation
___Hemorrhoids
___Painful Bowel movements
___Stomach pain
___Frequent Indigestion
___Food Allergies
___Scanty appetite
___Loses weight easily
___Acidity/ heartburn
___Diarrhea (loose stools)
___Ulcers
___Hypoglycemia/low blood sugar
___Fast metabolism/ strong appetite
___Skin disorder rash/irritation/itching/acne
___Sleepiness after eating
___Burping
___High blood sugar/ diabetic/prediabetic
___Sugar cravings
___Slow metabolism
___Low appetite
___Gains weight easily
___Candida
___Fungal Skin condition

Cardiovascular System

___Cold hands and feet
___Fast heartbeat
___Anemia/Low iron
___Pale Skin
___Varicose veins
___Tension/pain behind breastbone
___High Blood pressure
___Irregular Heartbeat
___Red skin
___General swelling/edema
___Low Blood Pressure
___High cholesterol

Reproductive System

___PMS
___Pelvic pain
___No Menstruation
___Mood swings
___Heavy/frequent flow
___Depression during cycle
___Irritability
___Swollen breasts
___Low sex drive
___High sex drive
___Peri/Menopausal
___Hot flashes
___Infertility
___Vaginal infections
___Prostrate issues
___Ovarian Cysts
___Painful intercourse
___Genital sores

Urinary System

___Frequent Day/Night urination
___Low back pain
___Incontinence/dribbling
___ Painful urination
___Frequent kidney/bladder infection
Color of urine (pale, dark, odor, cloudy, bloody)
___Little/Normal
___Urine Retention
___Excessive Thirst
___Kidney stones/pain in kidney area
___Dehydration

Muscular-Skeletal System

___Cracking/painful joints
___Arthritis
___Osteoperosis
___Broken Bones
___Inflexible/Stiff
___Tension in shoulders/neck
___Sprains/Strains
___TMJ/Jaw Pain
Areas of joint stress_____
___Swelling in joints
___Back Pain
___Spinal Problems

Endocrine System

___Rapid weight loss ___Chronic infection ___Swollen lymph node
___Auto-immune disease ___Chronic cold/flu

Habits – please describe past or present use and frequency
Drugs (pharmaceutical or recreational)_____
_____

Smoking (tobacco or marijuana)_____
_____

Alcohol_____
_____

Caffeine/Stimulants_____
_____

Food Cravings_____
_____

Exercise Routine_____
Do you have a regular yoga practice?_____

Eyesight/Hearing
Do you wear contacts/glasses_____ If yes, how long?_____
Have you had eye surgery_____If yes, please describe_____
Hearing loss_____
Dental history_____
Receding, Bleeding Gums, Cavities, Crowns, Root canals
Mental/Emotional
Check all that apply: ___anxiety___fear___stress/pressure___depression___anger___frustration
Rate from 1(lowest) to 10(highest)_____
Cause_____
_____
Ability to cope with emotions and challenges_____

Sleep Habits
Hours of sleep a night _____ Time you go to bed_____ Time you awaken _____
Check all that apply: ___sleep is restful ___sleep is disturbed ___difficult to get to sleep
___difficult to stay asleep___groggy upon waking ___take naps ___fatigue ___disturbed dreams

Spiritual Life
Do you have a regular spiritual practice?_____
Do you meditate?_____ Are you open to mantra therapy?_____