Wellness & Health History Intake Form

(The information you provide is completely confidential and for clinical use only)

***NOTE:** Please type or print clearly, save or scan and send to jodi@conscioussol.com*

CONTACT INFORMATION:
Full Name: _____

Address: _____

Work: _____ Home: _____ Cell: _____

Email addresses / Home email: _____ Work email: _____

How often do you check email? _____ Best way to contact you if necessary: _____

Other Social Media / Contact Info.:
Skype name: _____
Facebook: _____
LinkedIn: _____

BACKGROUND:
Age: _____
Height: _____
Date of Birth: _____
Place of Birth (country and/or state): _____

WEIGHT:
Current weight: _____
Weight six months ago: _____
One year ago: _____
Would you like your weight to be different? _____
- If so, what is your ideal weight? _____

STATUS:
Relationship status (single, married, divorced, dating, bi-sexual, homosexual, widowed):
_____
Children (#, ages): _____
Pets (#, type): _____

OCCUPATION:
Do you work or are you retired? _____
Where do you work? _____
Job Title: _____
If unemployed or retired, how long? _____
Hours of work per week: _____
Do you sit 6 plus hours or work at a desk? _____

How many hours are you on the computer? _____

HEALTH:
Please list your top health concerns:

_____
_____
_____

Other concerns and/or goals? List here:

_____
_____
_____
_____

SOCIAL:
Do you smoke? _____
Explain: (type, times/day, # of years)

_____
_____

Do you drink alcohol? _____
Explain:

_____
_____

At what point in your life did you feel best? (year, age, why do you think this was so?)

_____
_____

HOSPITALIZATIONS:
Any serious illnesses / hospitalizations / injuries? (list and dates)

_____
_____
_____
_____
_____

FAMILY HISTORY:
How is the health of your mother? _____
Still alive? _____ If no, how did she pass away? List here reasons / symptoms / diseases:

_____
_____

How is the health of your father? _____

Still alive? _____ If no, How did he pass away? List here reasons / symptoms / diseases:

_____
_____

LINEAGE:
What is your ancestry / heritage? Do you practice any traditions from your heritage?

_____

What blood type are you? (O, A, AB, B)

_____

How long you have lived in the US for if not from here? _____

SLEEP:
Do you sleep well? _____

How many hours per night? _____

Do you wake up at night? (# of times) _____
Why? _____

BODY SYMPTOMS:
Any pain, stiffness or swelling in your body? (please explain here)
_____
_____
_____

Past surgeries / minor operations? (List with dates)
_____
_____
_____
_____

(WOMEN ONLY)

MENSTRUAL CYCLE:
Are your periods regular? _____ How many days is your flow? _____
How frequent do you get your period? (every 25-28days) _____ Do you ever miss cyles? Y N
Painful or symptomatic? _____
Please explain:
_____
_____

Have you reached or are you approaching menopause? On any hormone replacement therapies (HRT's)?
Please explain:
_____
_____

BIRTH CONTROL HISTORY:
Have you taken birth control before? _____
How long? _____
When? _____
Are you currently on any type of BC and what type of BC?
_____
Have you had trouble getting pregnant? _____
Number of pregnancies: _____Births: _____
Birth Complications:
_____
_____

Do you experience yeast infections or urinary tract infections (UTI's) or in past?
Please explain:
_____
_____

Any other female problems list here:

_____
_____

(MEN ONLY)

Any problems with your prostate? _____
Heart problems? _____
Cancer? _____
Liver disease? _____
Other (please explain):

_____
_____

DIGESTION:
Constipation/Diarrhea/Gas? _____
Please explain:

_____
_____

How many bowel movement do you have daily? _____
Any pain? _____
Hemorrhoids? _____
Have you done any cleansing, colonics or enemas? _____
Please explain:

_____
_____

ALLERGIES:
Allergies or sensitivities? _____
Please explain:

_____
_____

SUPPLEMENTS:
Do you take any nutritional supplements? (please list type, dosage, usage):

_____
_____
_____
_____

MEDICATIONS:
Do you take any medications or drugs? (please list type, dosage, usage):

_____
_____
_____
_____

WATER:
How much water per day do you consume in ounces? _____
What type? (tap, spring, filtered, ionized, well, bottled): _____

ALTERNATIVE THERAPIES:
Any healers, helpers or therapies with which you are involved (acupuncture, chiropractic, PT, massage, hypnotherapy, etc…)?
Please list:

_____
_____
_____

EXERCISE:
What role does activity and exercise play in your life? _____
Are you active now? Y N _____
What is your exercise routine? Explain:

_____
_____
_____

FOOD:
What foods did you eat often as a child? (fastfood, organic, vegetarian, vegan, fried, local, farmers markets, grow your own, etc…) Explain here:

_____
_____

Breakfast:

_____
_____

Lunch:

_____
_____

Dinner:

_____
_____

Snacks:

_____
_____

Liquids / drinks/ sodas:

_____
_____

What's your food intake like these days?

_____
_____

Breakfast:

_____
_____

Lunch:

_____
_____

Dinner:

_____
_____

Snacks:

_____
_____

Liquids:

_____
_____

What type of food do you eat consistently? (organic, frozen, fried, fast food…) _____
What percentage of your food is home cooked? _____
Do you cook? _____
Where do you get the rest of your food from? (Walmart, Target, grocery store, farmers market, grow yourself, free, food stamps, organic market) _____
Do you have a food budget? Y N How much per week? _____
Do you have local farmers markets near you? _____
Have you ever done a CSA / Home organic box delivery / local pick up? Yes No _____

LIFESTYLE:
Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? If No, explain:

_____
_____

ADDICTIONS:
Do you crave sugar, coffee, cigarettes, or have any other known major addictions? Explain:

_____
_____

Do you eat sweets? During the day or at night _____
What types of sweets do you eat / How much? _____
Do you drink coffee? How many cups/day: _____
Any other addictions you would like to share? _____

ADDITIONAL INFO:

The most important thing I would change about my diet to improve my health is:

_____
_____

Please write anything else here you want to share so I can assist you better:

_____
_____
_____
_____