

# INTAKE FORM

(Please bring all medications and supplements with you for testing)

## Personal Information

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Have you had computerized sensitivity testing done in the past? \_\_\_\_\_

What are your main health concerns in order of importance to you personally:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## Current History

What other therapies are you currently using? (Please check all that apply)

- |                                      |  |  |  |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Exercise    | <input type="checkbox"/> Vitamins/Minerals | <input type="checkbox"/> Herbs               | <input type="checkbox"/> Chiropractor            |
| <input type="checkbox"/> Diet        | <input type="checkbox"/> Meditation        | <input type="checkbox"/> Reflexology         | <input type="checkbox"/> Prescription Medication |
| <input type="checkbox"/> Massage     | <input type="checkbox"/> Reiki             | <input type="checkbox"/> Naturopathic Doctor | <input type="checkbox"/> Medical Doctor          |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other: _____      |  |  |

What level of stress do you feel you are experiencing at this time in your life? [check one]

- Minimal       Average       Considerable       Unbearable

How well do you handle stress? \_\_\_\_\_

## Medication and Supplement History

Please list all supplements, herbs, homeopathics, and medications you are currently taking:

Medication/Supplement	Dosage	Since	Reason

## **Dietary Habits**

How many times a day do you eat:

Main meals \_\_\_\_\_ What times of the day: \_\_\_\_\_

Snacks \_\_\_\_\_ What times of the day: \_\_\_\_\_

On a typical day, what would you eat for:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

How much water do you consume daily? \_\_\_\_\_

What are your favourite foods? \_\_\_\_\_

What foods do you crave, if any? \_\_\_\_\_

Is there anything else about your health that you would like to share with me?

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## **Client Statement**

I understand and acknowledge that the services hereby provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnoses, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily. All information will be kept strictly confidential.

Name (Please print): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_

**Thank you. I look forward to working with you.**