INTAKE FORM

(Please bring all medications and supplements with you for testing – and please note: I will be testing acupuncture points on the fingers and toes)

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)

☐ Exercise	☐ Vitamins/Minerals	☐ Herbs	☐ Chiropractor
☐ Diet	☐ Meditation	☐ Reflexology	☐ Prescription Medication
☐ Massage	☐ Osteopathy	☐ Naturopathic Doctor	☐ Medical Doctor
☐ Acupuncture	☐ 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

Penny Ormsbee, RHN, RNCP/ROHP – Registered Holistic Nutritional Consultant
(902) 431-2326 - pormsbee@ns.sympatico.ca www.pennyormsbee.ca

Dietary Habits

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?

_____

_____

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: (Mobile) _____ (Other Daytime) _____

E-mail: _____ Subscribe to Newsletter: Yes No

Signature: _____

Thank you. I look forward to working with you.

Please note: You are not a good candidate for sensitivity testing if you are pregnant, have a pace-maker, or are under four years of age.

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