Consultation Intake Form

NAME: _____ **DATE:** _____

PURPOSE FOR CONSULTATION

List and rate your issues/goals/concerns on a severity scale of 0-10 (0 = no issue, 10 = worst imaginable)

Health or Personal issues/goals/concerns	Rating

Describe in your own words, your major concern and how it has affected your life

_____

_____

_____

What have you tried that has helped?

_____

_____

_____

_____

_____

_____

What have you tried that hasn't helped

_____

_____

_____

_____

_____

_____

Consultation Intake Form

HEALTH HISTORY

Please check all that apply and fill in pertinent information to the right of the item. Use another page if you need more room. If you have relevant medical/health reports, please include those as well.

- ☐ Chronic Pain _____
- ☐ Pelvic Concerns _____
- ☐ Joint/Spine/Bone _____
- ☐ Migraine/Headache _____
- ☐ Arthritis/Gout _____
- ☐ Dental Work _____
- ☐ Apnea/Snoring _____
- ☐ Cancer _____
- ☐ Chronic Fatigue _____
- ☐ Fibromyalgia _____
- ☐ PTSD _____
- ☐ Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Food Sensitivities _____
- ☐ Parasites _____
- ☐ Yeast/Fungal _____
- ☐ Liver Disease _____
- ☐ Kidney Disease _____
- ☐ Kidney Stones _____
- ☐ Gallstones _____
- ☐ Constipation _____
- ☐ Diarrhea _____
- ☐ Bowel Disease _____
- ☐ Nausea _____
- ☐ Urinary _____
- ☐ Reproductive _____
- ☐ Indigestion/Reflux _____
- ☐ Vision _____
- ☐ Lyme Disease _____
- ☐ Morgellons _____
- ☐ Mold Illness _____
- ☐ AIDS _____
- ☐ Hepatitis _____
- ☐ Skin Condition _____
- ☐ Thyroid Problems _____
- ☐ Adrenal Problems _____
- ☐ Stroke/Clots _____
- ☐ Seizure _____
- ☐ Heart Condition _____
- ☐ High Cholesterol _____
- ☐ Low Cholesterol _____
- ☐ High BP _____
- ☐ Low BP _____
- ☐ Asthma/Allergies _____
- ☐ Weak Immune _____
- ☐ Auto-Immune _____
- ☐ Autism/ADHD _____
- ☐ OCD _____
- ☐ Learning Disorder _____
- ☐ Brain Injury _____
- ☐ Depression/Anxiety _____
- ☐ Poor Memory _____
- ☐ Lack of Motivation _____
- ☐ Other Behavioral _____
- ☐ Other Neurological _____
- ☐ Addictions _____

Other Concerns: _____

Sleep:

Bed Time: _____ Fall Asleep Easily: Y / N

Wake Time: _____ Wake Easily: Y / N

Avg Hours Per Night: _____ Wake Up During Night: Y / N

Medications or Supplements to Support Sleep: _____

Stool:

How often do you have bowel movements? _____

What is the consistency and color? _____

Consultation Intake Form

Check all exposures (past and current) - include dates and known reactions.

Past	Current	Possible Toxin	Notes
		Metal Dental Fillings	
		Root Canals or Tooth Extractions	
		Vaccinations	**Please include a full list of vaccinations, dates given and any possible reactions**
		Medications/Antibiotics	
		Pesticides/Herbicides	
		Lead/Mercury/Other Heavy Metals	
		Harmful Molds	
		Eat/Drink from plastics	
		Eat microwaved food	
		Eat Non-Organic or GMO foods	
		Eat Foods with Food Coloring/Flavoring/Preservatives	
		Drink tap water without filtration	
		Eat at restaurants more than once per week	
		Smoke or drink alcohol	
		Street Drugs	
		Excessive exposure to fuel other than filling car tank	
		Exposed to man-made chemicals or waste	
		Live near a dump	
		Travel in an airplane often	
		Use harsh chemical cleaners	
		Use non-organic body care products	

Consultation Intake Form

CURRENT SUPPLEMENTS & MEDICATIONS

Supplement/Medication	Purpose

Consultation Intake Form

TRAUMA/EVENT TIMELINE

In chronological order, please list significant stressors

Approximate Date	Event/Trauma/Accident/Injury/Birth/Surgery/Hospitalization/Diagnosis

CURRENT LIFESTYLE

Work/Career: _____

How many servings do you get? ***Write the number, and circle D (day), W (week), or M (month).***

___ (D / W / M) Fruits	___ (D / W / M) Red Meat	___ (D / W / M) Pasteurized Dairy
___ (D / W / M) Vegetables	___ (D / W / M) Poultry/Eggs	___ (D / W / M) Restaurant Meals
___ (D / W / M) Nuts/Seeds	___ (D / W / M) Fish	___ (D / W / M) White Flour Foods
___ (D / W / M) Cups Water	___ (D / W / M) Soy Foods	___ (D / W / M) Caffeinated Drinks
___ (D / W / M) Cups Juice	___ (D / W / M) Raw Foods	___ (D / W / M) Prepackaged Foods
___ (D / W / M) Sodas	___ (D / W / M) Sugary Snacks	___ (D / W / M) Alcohol
___ (D / W / M) Whole Grains	___ (D / W / M) Tobacco Products	___ (D / W / M) Recreational Drugs

Consultation Intake Form

How often do you exercise, for how long and what do you do?

Exercise/Activity/Hobby	How often and for how long

Approaches I am willing to consider and/or learn more about as a part of my healing plan:

- ☐ Medical/Nutritional Testing
- ☐ Medical or Wellness Consults
- ☐ Cellular and/or Dental Detox Program
- ☐ Physical Therapy
- ☐ Chiropractic Care
- ☐ Counseling or Holistic Psychiatric Care
- ☐ Hypnosis/Hypnotherapy
- ☐ Colon Hydrotherapy
- ☐ Infrared Sauna
- ☐ Ionic Foot Bath
- ☐ Swedish or Deep Tissue Massage
- ☐ Manual Lymphatic Drainage Massage
- ☐ Pulsed Electromagnetic Field (PEMF)
- ☐ Reflexology
- ☐ Craniosacral Therapy
- ☐ Energy Healing (Reiki, Angelic, etc)
- ☐ Spiritual or Life Coaching
- ☐ Acupuncture or Acupressure
- ☐ Qigong/Tai Chi/Yoga
- ☐ BioLight Cold Laser
- ☐ Diet/Nutrition/Lifestyle Recommendations
- ☐ Fasting (Juice, Smoothie, Intermittent, etc)
- ☐ Supplements (Vitamins, Minerals, Herbs)
- ☐ Homeopathy
- ☐ Medical Cannabis

Choose Location of Services Preferred: (Circle One) In Person / Remote / Either

Financial Spending Comfort: We understand that services and tests can add up and we want to do our best to serve you in creating a plan that best serves all of your needs, including financial. We want to recommend solutions within your budget. What is your comfort level? (Circle One)

Lowest Cost Possible / Budget Conscious But Open / Finances Are Not A Major Concern

Anything else you want us to know?

_____