Center for Holistic Health, Nutrition, & Vacaville Thermography, Inc.

Your Individualized Health Management Solutions

New Client Health Intake Form

Please complete the following carefully. The information will help to build an individualized nutritional program for you.

Date: _ _____ Referred by: _____

Name: __ _____ Birthdate: __ _____ Age: ____

Address: _____ _____ City: _____State: ____ Zip: ___

Height: _____ Weight: _____ Marital Status: S M D W No. of children: _____

Email: _____

Phone: _____ Occupation: _____

Avoid taking any supplements for 2 days before evaluations. Please, wear no perfumes or lotions during your office visits.~~Thank you!

1. **Complaints**:

_____
_____
_____
_____

2. **What have you done so far to help with your conditions?**

____Chiropractor ___Medical doctor ____Massage ___Other practitioner
____Neuromuscular therapy ___Exercise ____Other? _____
_____

3. **Medications:**

_____
_____
_____
_____
_____
_____

4. **List any nutritional supplements that you regularly take:**

_____
_____
_____
_____

_____

_____

5. **List any "self-destructive" behaviors (alcohol, smoking, lack of exercise)**

_____

4. **Surgeries, accidents, trauma**: Check any that apply and the date and brief explanation

Tonsils	____	_____
Wisdom teeth	_____	_____
Broken bones	____	_____
Immunizations	____	_____
Hernia	____	_____
Piercings	____	_____
Elective surgery	____	_____
Other surgeries	____	_____
		_____
		_____

5**. Recreational drugs**: Do you currently or have you in the past used recreational drugs? _____

If yes, how long? _____

6**. Stress**: Please rate your current stress level on a scale of 1-10, 10 being the highest stress. ____

What are some factors you believe to be the reason for your stress?

_____

_____

What steps are you or have you taken to reduce your stress? _____

_____

7. **Sleep**: ____restful ____ restless ____ hard to get to sleep (GB) ____wake up during the night (St)
_____ bad dreams ____hard to wake up (Ad) ____other? _____

What time do you usually go to sleep? _____ Number of hours of sleep? _____

8. **Digestion**: ____adequate ____ poor ____acid reflux ____ burp often ____bloating
____burning pain in stomach ____ other?_____

9. **Urination**: ____ every 2-3 hours ____ too frequent ____ sense of urgency ____ too small amount
____too large amount ____ burning ____dribbling ____up at night often
____ other? _____

10. **Bowels**: ____ 3x daily, ____ 1x per day ____ skip days
____ normal amount ____ too little ____ too large
____ too hard ____ very soft ____diarrhea ____ normal consistency
____ brown ____ black ____clay colored ____other _____

11. **WOMEN**: Are you pregnant? ____ Are you breast-feeding? ____ Do you have monthly periods? ____
Date of last menstrual period? _____ Are you menopausal?
Have you had a hysterectomy? _____ When? _____
Menstrual cycle: Are you monthly periods regular (28 days)? _____
Number of days of menstrual flow? _____
Circle any of the following symptoms you experience with your period: Cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood, other_____

12. **Exercise**: What do you do for exercise/recreation? _____
_____

13. **Sunlight**: Amount of natural sunlight you receive daily outside? _____ Through windows? _____
Hours spent daily under fluorescent lights? _____ Do you use Chromalux light bulbs at home? _____
Work? _____

14. **Eyewear**: Do you wear glasses? _____ Contacts? _____

15. **Electromagnetic exposure**: How many hours do you spend daily?
Watching TV? _____ Working on a computer? _____ Talking on a cordless phone? ____
Talking on a cellular phone? _____ Wear a pager? ____ Wear a headset? ____ Fitbit? _____
Wear a wrist- watch? _____ Wear a hearing aid? ____ Ride in a vehicle? _____
Near electrical equipment for long periods of time? _____ Live next to transformer? ____
Smart Meter installed? _____
Live/work near a cell phone tower? _____ Use a hairdryer?_____ Other? _____
Do you sleep with your head at least one foot away from the wall? _____
Do you sleep with a clock-radio near your head? ____ Cell phone? _____Whole-house alarm? ____

16. **Clothing**: Is the majority of your clothing, natural fibers (cotton, linen, ramie, wool) _____ Synthetic (polyester, acrylic, nylon, rayon) _____ Blends _____

17. **Personal Care Products**: List the brand names that you use.
Shampoo_____ Shave Cream _____
Deodorant _____ Dish washing liquid/powder _____
Toothpaste _____ Laundry soap _____
Soap _____ Tub/tile cleaner _____
Hand/body lotion _____ Glass Cleaner _____
Facial Cleanser/Moisturizer _____ All-purpose cleaner _____
Hair spray _____ Perfume/c cologne _____
Contraception _____ Roach spray _____
Hair dye _____ Hair perm _____
Nail polish _____ Make-up _____
Other chemical exposure (yard, art, workplace)
_____

17. **Appliances**: Which do you use? Gas stove Electric stove Electric heater Electric blanket
Water bed Microwave Air purifier Water purifier

18. **Cookware**: What type of cookware do you use? Stainless steel aluminum iron Teflon-coated glass other _____

19. **Shower filter**: Do you use a shower filter? Yes No

20. **Pets**: Do you have a pet? No Yes, _____
Inside or outside? _____ Where does the pet sleep? _____

21. **Food Choices**: Please check any that apply to your regular food choices.

Pre-made foods	____yes	____no				
Red meat	____yes	____no	____organic	____non-organic		
Chicken	____ yes	____ no	____organic	____non-organic		
Turkey	____ yes	____ no	____ organic	____non-organic		
Fish	____ yes	____no	____ canned	____fresh	____frozen	
Vegetables	____ yes	____no	____canned	____fresh	____frozen	___GMO?
Fruit	____ yes	____no	____organic	____non-organic		
Whole grains	____yes	____no	Brand: _____			
Beans	____yes	____no	____canned	____ dried		
Eggs	____ yes	____no	____organic	____ non-organic		
Milk/dairy	____yes	____no	____organic	____non-organic	___raw	
Butter	____yes	____no	____organic	____non-organic		
Condiments	____yes	____no	List: _____			
Oils	____yes	____no	List: _____			
water			List: _____			

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22. **Food Stressors**. Please circle which foods you consume:

Coffee	Fried foods	Cow's milk	Bread
Caffeine drinks	Fast food	Yogurt	Crackers
Soft drinks	Potato or corn chips	Ice Cream	Bagels
Sweetened drinks	Roasted nuts	Cottage cheese	Buns
Alcohol	Mayonnaise	Sour Cream	Pasta
Chocolate (milk)	Margarine	Cheese	Muffins
Candy, sweets			Pastries/cookies

23. **Food Habits**:

Eating out: Do you eat out? _____ How often? _____ Where? _____

_____

Meal Habits: Do you? _____ skip meals often? _____have irregular eating times? _____eat past 7PM?

Additives: Do you avoid food/drinks that list additives/flavorings such as "MSG" on the label? ____yes ____no

Water: What water do you drink? ____tap water ____filtered water ____ distilled water ____flavored water

Food intake: Please fill out the attached Food Intake Journal, ***or below***. Be as specific as possible with what you usually eat for meals and the times, and please be honest. No judgments given; just data collecting.

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24. **Sleep Considerations**:

Bedding materials: What type of sheets, blankets, pillows do you use? _____

Mattress: What type of mattress do you sleep on? _____

Head direction: What direction does the top of your head point when you sleep? _____

Darkness: Is the room where you sleep completely dark or is there light in the room? _____

Alarm: Do you sleep with a whole-house alarm turned on (which uses infrared beams/sensors within the house)? _____

Personal Health Goals

1. Of your initial complaints, what are your top two or three health goals?

_____

_____

2. How important is your health to you, on a scale from 1-10 (1 low, 10 high)? _____

3. How much confidence do you have in medical drugs, on a scale from 1-10? _____

4. How much confidence do you have in your body's ability to heal itself if given the right food, nutrients/therapies on a scale from 1-10?

_____

5. How long would you give me to help you before you move on to another practitioner?

____2-3 weeks ___2-3 months ____ 3-4 months ___ 6 months ___9 months ___12 months

6. How much money are you willing to invest per month on your health? _____

My expectations of you:

Commitment

Perseverance

Application

Knowing that it takes years for our body to go through compensation and degeneration, it takes time to return to health and balance. By signing below you are showing that you are willing to **commit** to at least 3 months on a health program agreed upon by you and your health care practitioner, Christine Andrew, Certified Nutrition Consultant, **persevere** through the challenges of changing some habits, and **applying** the knowledge learned through the office visit sessions.

_____ _____ _____ _____

Client name Date Christine Andrew, CNC Date

Thank you for filling out this lengthy form. It truly helps to get an overall picture to help guide me into planning your health goals. Please use the following space to note anything of significance in regards to your health. (Past blood work, diagnosis, thoughts, past history of health, or anything else you would like to share).