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. We are a chemical free & EMF free clinic. Please refrain from wearing any scented personal products, scented lotions, or scented clothing. All electronic devices are to be turned off (ex; cell phones, Apple Watch, or tablets) during your office visits. We appreciate your complete understanding. ~~~Thank you!

1. **Complaints**:
   _____
   _____
   _____
   _____

2. **Since when have you been experiencing these health problems**? **And when /where do they mostly occur?**
   _____
   _____

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

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

_____

4. **Rx Medications:**

Name of drug?	How long?	Purpose?	Known side effects?

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

_____
_____
_____
_____
_____
_____

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

_____

7. **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 ____ _____

_____

_____

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

If yes, how long? _____

9. **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?

_____

_____

Which symptoms are you or have you been experiencing? Check any that apply:

- Anxiety
- tightness in chest
- Depression
- Difficulty concentrating
- Restlessness, tension
- Hyperactivity
- Irritability
- Fatigue
- Forgetfulness
- Headaches
- Sleep problems
- Heart palpitations
- Blood pressure problems
- Muscle tension
- Joint pain
- Skin conditions

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

_____

10. **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? _____

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)? _____

11. **Digestion**: ____adequate ____ poor ____acid reflux ____ burp often ____bloating ____burning pain in stomach ____ other?_ Please list:

12. **Bowels:** ____3x day _____ 1x day ____skip days _____normal amount ____too little ____ too large____ too hard ____ very soft ____diarrhea ____ normal consistency

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

    _____ brown ____ black ____clay colored ____other _____

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14. **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? _____ Underwire bra?_____ Implants? _____

    Do you use organic or non-organic Feminine Hygiene products? _____

    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_____

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15. **Exercise**: What do you do for exercise/recreation? How often?

_____

_____

16. **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? _____

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

18. **Electromagnetic exposure**: How many hours do you spend daily?

Watching TV? _____ Working on a computer? _____ Laptop? ____ Talking on a cordless phone? ____

Talking on a cellular phone? _____ Wear a pager? ____ Wear a headset? ____ Fitbit? _____

Apple Watch? _____ Wear a wrist- watch? _____ Wear a hearing aid? ____ Ride in a vehicle? _____

Drive an electric vehicle? _____

Are you or do you .....

Live or work near electrical equipment for long periods of time? _____ Live next to transformer? ____

Smart Meter installed? ____ Drive in an Electric Vehicle? _____ Wireless Internet or ethernet? _____

Live/work near a cell phone tower? _____ Use a hairdryer?_____ Bluetooth? ___ Alexa? _____

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? ____

Do you have any of the following symptoms?

- Exhaustion
- Difficulty finding words
- Dizziness
- Noise sensitivity
- Sensation of pressure in the ears
- Tinnitus
- Burning sensation in the eyes

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

20. **Personal Care Products**: List the brand names that you use.

Shampoo_____ Shave Cream _____

Deodorant _____ Dish washing liquid/powder _____

Toothpaste _____ Laundry soap _____

Mouth rinse _____ 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 _____

Soap _____ Breath Fresheners _____

Other chemical exposure (yard, art, workplace, paints, solvents, lubricants)

_____

21. **Appliances**: Which do you use? Gas stove____ Electric stove____ Electric heater____
Electric blanket ____ Water bed ____ Microwave ____ Air purifier ____ Water purifier____

22. **Cookware**: What type of cookware do you use? Stainless steel ____ aluminum ____ iron____

Teflon-coated ____ glass____ other _____

23. **Shower filter**: Do you use a shower filter? Yes____ No____

24. **Pets**: Do you have a pet? No ____ Yes, _____

Inside or outside? _____ Where does the pet sleep? _____

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25. **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: _____	
Raw Nuts	____yes	____no		
Nut Butters	____yes	____no	List: _____	

26. **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	Dried fruit		Pastries/cookies
			Cereal

27. **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 to list your typical breakfast, lunch, dinner, and snack foods eaten. 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.

28. **Oral Health**

Were you breast fed? ____yes ____no

Did you have fluoride treatments at your dental appointments or live in a highly fluoridated area? ____yes ____no

Did you have orthodontic treatment? ____yes ____no

Did you have a Frenectomy? (Under upper lip or under tongue) ____yes ____no

Did you have a cleft palate? ____yes ____no

Did you wear a head gear appliance? ____yes ____no

Are you currently wearing any dental appliances? ____yes ____no

Did you have any root canals? ____yes ____no

Did you have any teeth extracted? ____yes ____no

Did you have any mouth surgery? ____yes ____no

Do you chew gum? ____yes ____no

What brand?

Do you use Xylitol? ____ yes ____no

What color are your teeth? Yellow ____ yes ____no

Grey ____ yes ____ no

Do you have any mouth piercings? ____yes ____no

Any silver fillings? ____ yes ____no

Mouth piercings? Tattoos in mouth? ____yes ____no

29. **Toxicant Stressors:**

Are you now or have been exposed to any of the following:

- Non-organic paper products- paper towels, napkins, toilet paper, Kleenex? _____
- Fire Retardants? _____
- Tanning agents?_____
- Insect Repellents? _____
- Plastics? _____
- Parabens? _____
- Cigarette smoke, Forest fire smoke, Gas fumes? _____
- Dry cleaning? _____
- Metal products? _____

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/able 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. Your body works in concert. Each system depends on another system to be in balance. Nothing works in isolation. 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, **persevere** through the challenges of changing some habits, and **applying** the knowledge learned through the office visit sessions.

Your practitioner here at the center is **committed** to **persevere** through your health challenges to give you the best possible experience and success and to help you **apply** what you have learned so that you can achieve your health goals.

_____ _____ _____ _____

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).