I

Wellness Intake Form

Name: _____ **Date:** _____

Email Address: _____

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____
How many servings of vegetables do you consume per day? _____
How many servings of protein do you consume per day? _____
How many servings of bread/crackers/pasta do you consume daily? _____
Do you consume artificial sweeteners? __Yes __ No If yes, what brands? _____
Do you consume fast food? __ Yes __ If yes, what do you typically eat? _____
Do you eat breakfast? __ Yes __ No If no, what time is your first meal of the day? _____
Do you consume alcoholic beverages? __ Yes __ No If yes, how many per week? _____
Do you consume coffee? __ No __ Yes If yes, how many cups per day? _____
Do you consume dietary supplements? __ No __ Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

____ Lose weight ___ More energy ___ Sleep better ___ Improve digestion

____ Improve blood work ___ Prevent problems ___ Anti-aging support ___ Improve general health

If you could improve ONE thing about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

1. What number best describes how you feel about your health today? _____
2. What health goal do you want to achieve?: _____

NOTE: In our commitment to your health, our office provides our patients with access to a free online resource for education, science and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

__ Health Reality Check __ The Meaning of Essential Nutrients __ Creating Optimal Health __ Other _____
__ Customizing Your Health Plan __Healthy Age Management __ Genetics and Health __ Healthy Weight Loss

Symptom Checklist

DATE:_____

Symptom Point Scale

Use the point scale to rate your symptoms based on how you've been feeling over the past 30 days.

0= Never or almost never have the symptom
1= Occasionally have it, effect is not severe
2= Occasionally have it, effect is severe
3= Frequently have it, effect is not severe
4= Frequently have it, effect is severe

GRAND TOTAL_____

Digestive Tract
- ❑ Belching
- ❑ Bloated feeling
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Passing gas
- ❑ Stomach pains
- ❑ Vomiting

Ears
- ❑ Drainage from ear
- ❑ Ear aches
- ❑ Ear infections
- ❑ Hearing loss
- ❑ Itchy ears
- ❑ Ringing in ears

Emotions
- ❑ Aggressiveness
- ❑ Anxiety/fear
- ❑ Depression
- ❑ Irritability/anger
- ❑ Mood swings
- ❑ Nervousness

Energy & Activity
- ❑ Apathy
- ❑ Fatigue
- ❑ Hyperactivity
- ❑ Lethargy
- ❑ Restlessness
- ❑ Sluggishness

Eyes
- ❑ Blurred vision
- ❑ Dark circles
- ❑ Itchy eyes
- ❑ Sticky eyelids
- ❑ Swollen eyelids
- ❑ Watery eyes

Head
- ❑ Dizziness
- ❑ Faintness
- ❑ Headaches
- ❑ Insomnia
- ❑ Lightheadedness

Joint & Muscles
- ❑ Aches in muscles
- ❑ Arthritis
- ❑ Feeling of weakness
- ❑ Limited movement
- ❑ Pain in joints
- ❑ Stiffness

Lungs
- ❑ Asthma/bronchitis
- ❑ Chest congestion
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Wheezing

Mind
- ❑ Confusion
- ❑ Learning disabilities
- ❑ Poor concentration
- ❑ Poor memory
- ❑ Stuttering/stammering

Mouth & Throat
- ❑ Canker sores
- ❑ Chronic coughing
- ❑ Gagging
- ❑ Often clear throat
- ❑ Sore throat
- ❑ Swollen tongue/lips/gums

Nose
- ❑ Excessive mucous
- ❑ Hay fever
- ❑ Sinus problems
- ❑ Sneezing attacks
- ❑ Stuffy nose

Skin
- ❑ Acne
- ❑ Dermatitis
- ❑ Eczema
- ❑ Excessive sweating
- ❑ Flushing/hot flashes
- ❑ Hair loss
- ❑ Hives/rashes
- ❑ Itching

Weight
- ❑ Binge eating
- ❑ Compulsive eating
- ❑ Cravings
- ❑ Excessive weight
- ❑ Underweight
- ❑ Water retention

Other
- ❑ Anaphylactic reactions
- ❑ Chest pains
- ❑ Frequent illness
- ❑ Genital itch
- ❑ Irregular heartbeat
- ❑ Rapid heartbeat
- ❑ Urgent urination

Patient's Name:_____

Typical Diet Diary

	Breakfast	Lunch	Dinner	Snacks	Drinks	Symptoms
Mon						
Tues						
Weds						
Thurs						
Fri						
Sat						
Sun						

Medications

Supplements