INTERNAL USE: PCID: _____ Health Goal: ____

Wellness Intake Form

Name: _____ **Date:** _____ **Age:** _____
Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Email Address: _____ **Phone:** _____ **Date of Birth:** ___/___/___

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

Initial Symptom Checklist

Patient Name: _____
Present Weight: _____
Immuno Test Date: _____
Date Diet Started: _____ Checklist Date: _____
Medical Diagnosis (if any): _____
_____

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*

Be sure to enter your Symptom Progress Checklist scores in the comparison chart on page 40.

DIGESTIVE TRACT
___ Belching
___ Bloated feeling
___ Constipation
___ Diarrhea
___ Nausea
___ Passing gas
___ Stomach pains
___ Vomiting
___ Total

EARS
___ Drainage from ear
___ Ear aches
___ Ear infections
___ Hearing loss
___ Itchy ears
___ Ringing in ears
___ Total

EMOTIONS
___ Aggressiveness
___ Anxiety/fear
___ Depression
___ Irritability/anger
___ Mood swings
___ Nervousness
___ Total

ENERGY & ACTIVITY
___ Apathy
___ Fatigue
___ Hyperactivity
___ Lethargy
___ Restlessness
___ Sluggishness
___ Total

EYES
___ Blurred vision
___ Dark circles
___ Itchy eyes
___ Sticky eyelids
___ Swollen eyelids
___ Watery eyes
___ Total

HEAD
___ Dizziness
___ Faintness
___ Headaches
___ Insomnia
___ Lightheadedness
___ Total

JOINTS & MUSCLES
___ Aches in muscles
___ Arthritis
___ Feeling of weakness
___ Limited movement
___ Pain in joints
___ Stiffness
___ Total

LUNGS
___ Asthma/bronchitis
___ Chest congestion
___ Difficulty breathing
___ Shortness of breath
___ Wheezing
___ Total

MIND
___ Confusion
___ Learning disabilities
___ Poor concentration
___ Poor memory
___ Stuttering/stammering
___ Total

MOUTH & THROAT
___ Canker sores
___ Chronic coughing
___ Gagging
___ Often clear throat
___ Sore throat
___ Swollen tongue/lips/gums
___ Total

NOSE
___ Excessive mucous
___ Hay fever
___ Sinus problems
___ Sneezing attacks
___ Stuffy nose
___ Total

SKIN
___ Acne
___ Dermatitis
___ Eczema
___ Excessive sweating
___ Flushing/hot flashes
___ Hair loss
___ Hives/rashes
___ Itching
___ Total

WEIGHT
___ Binge eating
___ Compulsive eating
___ Cravings
___ Excessive weight
___ Underweight
___ Water retention
___ Total

OTHER
___ Anaphylactic reactions
___ Chest pains
___ Frequent illness
___ Genital itch
___ Irregular heartbeat
___ Rapid heartbeat
___ Urgent urination
___ Total

_____ GRAND TOTAL

Typical Diet Diary

	Breakfast	Lunch	Dinner	Snacks	Drinks	Symptoms
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Vitamins/Supplements_____

_____

Medications:_____

_____