WASHINGTON PARK
CHIROPRACTIC

heal thrive evolve

Nutrition Client Intake Form

Name_____ Date_____

Address_____ City_____ State____ Zip _____

Cell Phone (___)_____ Home Phone (___)_____ Work Phone (___)_____

Email_____ Best Method of Contact __Phone __Email __Text

DOB_____ Weight _____ Height _____

Marital Status_____ Number of Children _____

Referred By _____

What brought you in today? _____

_____

How long have you had this issue? _____

Have you seen a physician for this issue?_____

Have you undergone any treatment? _____

If yes, please explain_____

_____

Medical Information

Please list all medications and doses you are currently taking:_____

_____

Please list all supplement and vitamins you are currently taking_____

Kebbie Stine, MNT kebbiestine@gmail.com (720)971-8447

_____

Approximate number of bowel movements per day __1 __2 __3 __4 __5
Consistency?_____

What color is your urine typically? _____

Medical History

Have you had any surgeries or procedures that would affect your treatment? Please list

_____

Please circle any that apply to you currently:

Alcoholism	Crohn's Disease	Gastric/Duodenal Ulcer	Osteoarthritis
Alzheimer's Disease	Depression	Head Injury	Osteoporosis
Anemia	Diabetes	Hepatitis	Pancreatitis
Asthma	Eating Disorder	High Blood Pressure	Pneumonia
Autoimmune Disease	Eczema	High Cholesterol	Psoriasis
Bronchitis	Emphysema	HIV	Rheumatoid Arthritis
Cancer	Endometriosis	Intestinal Parasites	Skin Condition
Cardiovascular	Epilepsy	Leaky Gut	STD
Celiac Disease	Fibromyalgia	Mental Illness	Stroke
Chronic Fatigue	Genetic Disorder	Migraine Headaches	Thyroid Condition
Colitis	Glaucoma	Mono	Other _____

Females:

Are you peri-menopausal or menopausal?_____ Date of last period_____

Number of pregnancies_____ Number of births_____

Are you currently taking birth control?_____

Are you currently trying to conceive?_____

Do you suffer from PMS?_____ Symptoms_____

Personal Information

Occupation_____ Normal work hours_____

Do you enjoy your job? ___Yes ___Sometimes ___ No

How would you rank your stress level from 1-10? _____

How many hours of sleep do you get on average? _____ Normal sleep hours_____

Do you take naps? _____If so, how often?_____ Do you wake feeling refreshed? _____

What do you do to relax? (ex-watch tv, read, get outdoors, etc)_____

_____

Are you physically active? _____ How often? _____ Duration? _____

What physical activities do you enjoy doing?_____

_____

Do you consume alcohol?_____ How many times/week?_____

Do you smoke tobacco?_____ Do you smoke marijuana?_____

Do you use other recreational drugs?____ How often?_____

Goals

What are your goals for today?_____

_____

Do you see any obstacles in obtaining your goals?_____ _____

_____

Do you have a support system to help you achieve your goals? (ie-friends, family, coworkers, etc)_____

How committed are you to change?_____

_____

Everything I have written and answered in this form is true to the best of my knowledge. I will update Whole Choice Nutrition on of any significant changes. I understand and agree that this confidential information of my medical and health history will be maintained by Whole Choice Nutrition and will not be released to any individual except when I have authorized this release in writing or when required by law.

Signature _____ Date _____

Signature of Legal Guardian if Applicable_____ Date_____