Patient Health Intake Form

Please complete all fields marked with an asterisk (*).

Contact Information

- **Email**: _____
- **Phone Number**: _____
- **Name**: _____
- **Time Zone**: _____
- **Today's Date**: ___ / ___ / _____ (MM/DD/YYYY)
- **Street Address, City, State, Zip Code**

Personal Information

- **Date of Birth**: ___ / ___ / _____ (MM/DD/YYYY)
- **Occupation**: _____

Height and Weight

Health History

- **Describe Health Problems**:
- **What treatment have you tried? Did anything work?**
- **Have you lived or traveled outside of United States?** □ Yes □ No
- **Have you taken oral steroids?** □ Yes □ No
- **Have you had any recent major life changes? If yes, please explain**:
- **Do you have food sensitivities?** □ Yes □ No
    - If yes, please list: _____
- **How often do you take antibiotics?** _____
- **List vitamin, mineral, and other nutritional supplements you are taking currently**:

Diet & Digestive Health

- **What is your typical daily diet? Breakfast, lunch, dinner**:
- **Do you have any symptoms after eating, such as belching, bloating, gas, abdominal pain?**:
- **If yes, is it immediate or after 2 hours?** _____
- **How many bowel movements do you have per day?** _____
- **Do you drink alcohol? Daily? Weekly?** _____

Environmental Exposures

- **Do you have mercury amalgam fillings in your teeth?** □ Yes □ No
- **Have you been exposed to toxic metals at your job or home?** □ Yes □ No
- **Have you had any exposure to mold?** □ Yes □ No

Stress & Lifestyle

- **How would you rate your current level of stress 1-10?** (1-very low to 10-very high)
- **Do you exercise regularly? How many times per week, what type of exercise?**
- **Do you struggle with insomnia or interrupted sleep? Do you have a hard time falling or staying asleep?**

Women's Health (if applicable)

- **Do you have a menstrual cycle? Is it regular? _____**
- **Are you pre or post-menopausal? _____**
- **Do you have problematic symptoms related to your menstrual cycle? Such as mood changes, flow?**

Additional Health Concerns

- **Do you have a hard time losing, gaining, or maintaining your weight? _____**
- **Do you have headaches or migraines? If so how often? _____**
- **Have you been told you have thyroid dysfunction? _____**
- **Do you struggle with anxiety or depression? Or seasonal depression? _____**
- **Do you have any skin issues? Dry or flaky skin?**