CLINICAL INTAKE

Name		**Date / /**
Ethnicity Section 1.1		
Email Address		
Complete Address		
Age / Sex		
Phone(s)		
Occupation		
D.O.B / Birthplace	/ /	
Places lived		
Marital Status		
Height / Weight(lbs)		

List Major Events of your health history illness,surgery,accidents,toxin,heavy metal exposure and age occurred **Section 1.2**
Please list any present complaints **Section 1.3**
Do you have any allergies If yes explain under **Section 1.4**

	Do you have any of the following :		
Comfort	**Sensations**	**Digestion**	**Other**

	Which of the following apply :		
Appetite	**Thrist**	**Sleep / Emotions**	**Energy Levels**

Describe any pain, stiffness or swelling in your body **Section 1.5**

Grains Eaten Choose all that apply	Section 1.	
Legumes Eaten Choose all that apply	**Section 1.7**	
If Eaten Choose all Sweetners and nuts that apply	Section	
If Eaten Choose all Meats,Dairy,Fruits and Vegetables that apply	Section 1	
Do you have or use the following :		

If deep frying food what kind of oil is used				
Type of spices used				
Ever had house pets during your life (explain)				
Ever Eaten Sushi or Raw Meat (If yes were parasites ever discovered)				
Medications taken list all that apply		**Duration**	**Years**	**Months**
Street Drug History Choose all that apply				

Women's Health

Period	**Children**	**Urine**

	Explain in Section 1.7	
	Men	
Do you have any issues Section 1.7		
	Favorite Colors,Seasons,Flavors	
Tastes	**Seasons**	**Colors**
	Describe Current Diet	
Currently on a diet?	**Organic%**	**If so how long?**
Birth Control pill history (list total number of months or years		
Note: If emailing this form and if convenient please send a recent photo to help with facial assessment		