Grassroots Health Client Intake Form

Name:____________________________________
Date:_____________Age:________Sex:_______

What is your main purpose in coming here today?____________________________
____
____

What are your main health concerns and complaints?__________________________
____
____

What level of stress are you feeling at present?
Minimal_____Average_____Considerable______Unbearable________

What are the main causes of your stress?

Family	______	Health	______	Unfulfilled Expectations	______
Work	______	Personal	______	Other	______
Financial	______	Relationship	______		

How does your stress manifest itself?______________________________________
____

What, if any coping mechanisms do you use?________________________________
____

Do you partake in any kind of exercise? If so what kind and how often?_________
____

How many hours on average do sleep each night?___________________________
At what time do you go to bed?______________Awaken?______________________
Do you wake feeling rested?____

What is your occupation?____
Do you enjoy your work?____
How many hours a day do you work?______________________________________

Do you smoke? If yes, how often and for how long?__________________________
____
What are your interests and hobbies?______________________________________

Do you partake in a spiritual practice? (i.e. church, religious group, meditation)?
____

Do you vacation regularly?____
When was your last vacation?____

MEDICAL HISTORY

If you are you currently taking any medication, what is it and what is it for?_____
____
____
____

Are you taking any vitamins, minerals, other supplements, herbs or homeopathics? Please list dosages.___________________________________
____

Any known allergies or sensitivities?___________________________________
____

Have you ever been diagnosed with an illness? Explain.____________________
Have you ever been hospitalised? Explain.______________________________

How often do you have a bowel movement?____________________________
Do you have to strain to do so? Yes__________No_________Sometimes________
Related to a particular food?_______________________________________
Do you experience loos stools? Yes__________No_________Sometimes________
Related to a particular food?_______________________________________

Do you use recreational drugs? If yes how often and what type?_____________
____

FAMILY HISTORY

Please indicate if family members have dealt with the following:
(Use 'M' -mother, 'F' -father, 'G' -grandparent, 'S' -sibling, 'O' –other).

______Heart Disease	______Diabetes	______Allergies
______Hypertension	______Arthritis	______Mental Illness
______Intestinal Diseases	______Osteoporosis	______Alcoholism
______Asthma	______Ulcers	______Kidney Disease
______Gall Bladder	______Cancer –type_________________	

FEMALES

Are you or could you be pregnant?____________________________________
Are you experiencing peri-menopausal or menopausal symptoms?____________
If yes, specify:____
Do you experience PMS Symptoms?___________________________________

DIETARY HABITS

How many times a day do you eat?
Main meals_______________Times of day _________________________
Snacks __________________Times of day _________________________

Do you eat meals: Y or N
With family ________Home alone _______On the run _______
Restaurant _________ Fast Food _________

Give an example of your typical meals in a day:
Breakfast: ____
____
____
Lunch: ____
____
____
Dinner: ____
____
____
Snacks: ____
____
____

How many of the following do you consume during a day?

______ Beer	______Wine	______Coffee
______Water	______Other Alcohol	______Diet Pop
______Pop	______Milk	______Tea
______Herbal Tea	______Bottled juice	______Fresh juice
______Candy	______Fat Food	______Fried Foods

Do you experience any of the following symptoms? Please indicate with a 1 –mild or rarely occurring; 2 –commonly occurring and a 3 –occurs often. Leave blank if not applicable.

General fatigue or weakness ____
Difficulty losing weight ____
Frequent illness or infections ____
Smoker _____
Drink more than 2 coffees/day _____
Bad breath, body odour ______
Bags under eyes _____
Craves sugars, breads, alcohol _____
Gas, bloating after meals ________
Belching after meals ______
Used antibiotics in last 10 years ____
Allergies _______
Poor memory and concentration _____
Skin problems _____
Exposure to toxins/chemicals _____
Sinus inflammation, discharge _____

Frequent mood swings _______
Depressed/irritable ______
Brittle fingernails ______
Dry, brittle hair _____
Anxiety, nervousness ______
Insomnia ______
Muscle cramps ______
Yeast and fungus problems _____
Cold hands/feet _____
Varicose veins ______
Feeling out of control _____
Excessive mucous _____
Joint pain _____
Dry, flaky skin _____
Headaches. migraines _____

CLIENT STATEMENT:
I understand and acknowledge that the services proided are at all times restricted to consultation on the subject of health matters intended for general well-bein and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: _______________

Signature: ____

Name (print): ____

Address: ____

City:____________________Province:________Post Code:___________

Phone: (Hm) ________________ (Wk) ____________________________