Alternative Health
BY CHRYSTAL

Individual Health Intake Form

Name:_____ Day Phone:_____

Address:_____ Cell Phone:_____

City:_____ State:_____ Zip:_____

Email:_____

Looking for relief from what 3 top symptoms:_____

_____

_____

What type of exercise do you do weekly? ☐ Cardio ☐ Weights ☐ None

How many ounces of water do you drink daily? _____

What type of water do you drink? ☐ Tap ☐ Distilled ☐ Bottled ☐ Spring

Do you eat: Breakfast ☐ Lunch ☐ Dinner ☐

How many times per day do you eliminate your bowels? _____

Do you take digestive enzymes on a daily basis? ☐ Yes ☐ No If yes, what brand? _____

How often do you consume the following? (Once a day, twice, all day)

Soda _____ Coffee _____Whole Grains _____

Fast Food _____Milk _____ White Flour _____

Raw Fruit _____ Meat _____Raw Veggies_____

Choose the types of food you crave: ☐ Salty ☐ Chocolate ☐ Sweets ☐ Breads

On a scale of 1 to 10 (10 being the highest level) how much daily energy do you have? _____

How many hours of spiritual enrichment do you engage in weekly? _____

How many hours are spent with family/friends on average on a weekly basis? _____

How many hours of sleep do you get each night? _____ How many hours of sleep do you need? _____

How did you discover our office and the professional services we offer?

☐ Friend/Referral ☐ Social Media ☐ Medical Doctor ☐ Other

Please complete this general health history and wellness survey. It will provide us with valuable information to better understand your history and long-term needs.

Health Concerns or Symptoms and How They May Influence Your Life

Do you have a current health/life situation that you are concerned about? If so, please describe:

_____

_____

_____

When did this situation begin? _____

Have you done anything about this situation such as seek advice or find treatment for it? ☐ **Yes** ☐ **No**

If so, what was done? _____

_____

Did it seem to work? _____

If so, what was different about you after treatment? _____

_____

Any type of changes in your situation after treatment? ☐ **Yes** ☐ **No** Please explain: _____

_____

IF NOT, please answer the following:

Is there any activity during which you *forget* about this situation? _____

Is there any time of day where this situation is ***more noticeable*** or ***less noticeable***? _____

If this situation, were to go away, what would be different about your life? _____

_____

_____

I understand that I am here to learn about nutrition and better health practices. I will be offered information about food supplements and herbs as a guide to general good health. This consultation is offered as a personal ministry.

I fully understand that those who counsel me are not medical doctors, and I am not here for medical diagnostic purposes or treatment procedures. I acknowledge that I am not, on this visit (by phone or in person) or any subsequent visit, an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed here with this office are always restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature: _____ Date: _____

By typing your name this represents your signature.

Submit