



INTAKE FORM

Eat in Peace: Wellness Consulting
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Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Best way to contact you: _____

Date of birth: _____ Place of birth: _____ Age: _____ Height: _____ Weight: _____

Highest weight ever: _____ Year: _____ Lowest weight ever (as an adult): _____ Year: _____

Occupation: _____ How long: _____

On a scale from 1 (hate) to 10 (love), do you like your work? _____

Previous occupation: _____ Education (highest level attained): _____

Relationship status: _____ Number of times Married: _____ Divorced: _____ Widowed: _____

Are you pregnant or planning to get pregnant? Yes No

Number of children? ____ Breastfeeding? Yes No

Recent Surgery? _____ Trauma? _____ Infection? _____

Where and when have you lived or traveled outside the U.S. and Canada: _____

How did you find out about Eat in Peace? _____

REASONS FOR COMING TO SEE ME

Please list your major health concerns in order of importance:

Duration?

1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HISTORY

Circle illnesses which have occurred in any of your blood relatives:

Diabetes	Cancer	Bleeding tendency	Kidney Disease	Heart Disease
Stroke	High blood pressure	Nervous illness	Allergy/Asthma	Addiction
Arthritis	Obesity	Depression	Headaches/Migraines	Osteoporosis
Lyme Disease	Liver Disease	Metabolic Syndrome/Insulin Resistance		
Eczema/psoriasis	Digestive issues	Thyroid disease	Respiratory disease	

Relationship	Alive/Deceased	Present health or cause of death
Father	_____	_____
Mother	_____	_____
Brother	_____	_____
Sisters	_____	_____
Children/ages	_____	_____

ACTIVITY LEVEL (choose only one)	Type of activity?	Duration?
Sedentary (little or no exercise, desk job or bed ridden)	_____	_____
Light activity (exercise 1-3 days per week)	_____	_____
Moderate activity (exercise 3-5 days per week)	_____	_____
Very active (exercise 6-7 days per week)	_____	_____
Extremely active (hard daily exercise or physically demanding job)	_____	_____

Are you satisfied with your energy levels? Yes Sometimes No
 On a scale of 1 (I feel sick) to 10 (I feel fantastic), where would you rate your sense of well being? _____

DIET

How many times per week do you eat at restaurants? _____
 How many times per week do you cook or prepare food at home? _____
 Do you have any special dietary restrictions or preferences? Are there any foods that you avoid and why?

Have you ever followed a specific diet? If so, which one(s), for how long, and why? _____

What foods do you crave, if anything?

What substances (food or environmental), if any, are you allergic or sensitive to? _____

What beverages do you usually consume? _____

GENERAL HEALTH QUESTIONS

Do you have regular bowel movements? Yes No How many per day? _____ Per week? _____
 Is it ever difficult to move your bowels? Yes No
 Typical bedtime _____ Typical hours of sleep per night _____

Do you feel rested upon waking? Yes No Do you feel that your sleep is adequate? Yes No
 Are you satisfied with your primary relationship and/or support system? Yes No
 What would you describe as the predominant emotions in your life right now? _____

On a scale from 1 (low) to 10 (high), how stressful is your:

Work _____

Health status _____

Social/family situation _____

MISCELLANEOUS ITEMS

Name and phone number of regular physician: _____

Date of last appointment with physician: _____ Reason for that appointment: _____

Other health care providers? _____

Medications currently or previously used (including prescriptions and over the counter medications):

Name & reason for taking	Dosage/Frequency	Duration (years, months, weeks)?

Supplements currently used (vitamins/herbs):

Type/Brand & reason for taking	Dosage/Frequency	Duration (years, months, weeks)?

Please list major events in the last ten years of your life and the dates they occurred (included births, deaths, marriages, divorce, accidents, moves, job changes, miscarriages, illness and anything else you feel greatly impacted your life).

Date	Event
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