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