OPTIMUM VITALITY

FUNCTIONAL NUTRITION · COLD LASER · YOGA

New Client Intake Form

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Sex: ☐ Male ☐Female

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home/Work Phone: _____

Email: _____

Occupation: _____Employer:_____

Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents), **health and/or life threatening activities** (fireman, etc.) or **are you around computers, power lines/towers, cell phones**? ☐ No ☐ Yes

Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Names and ages of children: _____

How did you hear about us/who were you referred by? _____

What health benefits do you want to achieve by working together?

☐ Improved eating habits ☐ Improved well-being ☐ Decreased inflammation ☐ Weight reduction

☐ Increased energy ☐ Improved sleep ☐ Increased stamina ☐ Other _____

What are your main health concerns and/or chief complaints?

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

What things can't you do due to your chief complaints? What are your physical health ailments keeping you from? _____

Previous treatment for complaint(s)?

Physical Health

Height (ft): _____ Weight (lbs): _____ Goal weight (if applicable): _____

Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks

List any medical problems currently being managed by a physician: _____

_____

List any surgeries with dates: _____

_____

List family history of serious illness: _____

_____

List allergies to any food, drugs or other known allergies: _____

_____

List all scars, tattoos & piercings:

_____

_____

List all supplements or homeopathics including dose:

_____

_____

_____

List all Medications:

Medication List	Do you want to get off this medication?	OFFICE USE ONLY	
		Date/Amt of Reduction per MD	**Or Elimination**
	YES NO		
	YES NO		
	YES NO		
	YES NO		
	YES NO		
	YES NO		

Have you been formally diagnosed by a physician with Diabetes or Insulin Resistance? YES NO

Are you currently undergoing any of the following cancer treatments?
Chemotherapy Radiation Trial Drugs

On average, how many hours do you sleep per night? ☐ <5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you wake up feeling refreshed? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes

If yes, why and when: _____

Have you been diagnosed with any clinical condition or disease? ☐ No ☐ Yes

If yes, what: _____

Have you ever been in a motor vehicle accident? ☐ No ☐ Yes

If yes, what kind and when: _____

Were you evaluated and treated after each accident? ☐ No ☐ Yes

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes

If yes, please explain: _____

Have you had any imaging performed in the last year? ☐ No ☐ X-ray ☐ MRI ☐ CT ☐ PET

Have you had blood work performed in the last year? ☐ No ☐ Yes

Were your test results in medically normal ranges? ☐ No ☐ Yes

If not, which results were abnormal? _____

Bowel Movements/day _____

General Lifestyle

What is your activity level on a scale from 1-10? (10 being very active) _____

What is your average energy level on a scale of 1-10 (10 being the optimal energy level you think you *should* have)? _____

Do you feel you get adequate sleep?	☐Yes ☐No	_____
Do you wake rested?	☐Yes ☐No	_____
Do you wake during the night? At what time?	☐Yes ☐No	_____
Do you sleep next to any electronic devices?	☐Yes ☐No	_____
Do you exercise?	☐Yes ☐No	_____
Do you follow any particular diet?	☐Yes ☐No	_____
Do you consume caffeine daily?	☐Yes ☐No	_____
Do you use tobacco?	☐Yes ☐No	_____
Do you consume alcohol?	☐Yes ☐No	_____
Do you feel you've ever had a problem with overuse of drugs or alcohol?	☐Yes ☐No	_____
Do you have a good support system?	☐Yes ☐No	_____
Do you have a spiritual practice?	☐Yes ☐No	_____

What are the main stresses in your life? _____

Have you experienced any particularly life-changing stressful events? _____

_____

What do you do to de-stress?_____

What are your some of your hobbies? _____

Mental/Emotional Health

Rate the current level of **personal stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **relationship stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **health stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **family stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **occupational stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Chemical Health

Do you choose to get annual flu shots? ☐ No ☐ Yes

Have you used antibiotics in the last year? ☐ No ☐ Yes

How many glasses of water do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of coffee/energy drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of juice/soda/sports drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods)? ☐ No ☐ Yes

If yes, how many servings per day? _____

Do you eat refined sugar? ☐ No ☐ Yes

If yes, how many servings per day? _____

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum)? ☐ No ☐ Yes

Do you have any food/drink allergies, sensitivities or intolerances? ☐ No ☐ Yes: _____

Do you smoke? ☐ No ☐ Yes ☐ I used it for: _____ years

Are you/have you been exposed to second-hand smoke? ☐ No ☐ Yes

Food Health

Please list the foods you commonly eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many cups of vegetables do you eat per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

What foods do you crave? _____

Do you mostly cook at home or do you mostly eat out? COOK EAT OUT

Are you an emotional eater? YES NO

ANGER SADNESS HAPPINESS GRIEF ANXIETY DEPRESSION OTHER

Do you eat out of boredom? YES NO

What food is your favorite/your weakness? _____

Symptoms

Please check the boxes of symptoms that you are currently experiencing, or have experienced in the **past 12 months**:

Wood:

- ☐ Back pain
- ☐ Brittle nails
- ☐ Bursitis/Tendonitis
- ☐ Headaches/Migraines
- ☐ Gallbladder problems
- ☐ Gout
- ☐ Irritable/Angry
- ☐ Hepatitis/Liver disease
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Muscle weakness
- ☐ Paralysis

Fire:

- ☐ Anxiety
- ☐ Bleed or bruise easily
- ☐ Chest pain/pressure
- ☐ Depression
- ☐ Environmental sensitivities
- ☐ Fainting/Dizziness
- ☐ Food intolerances
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Hot/Cold intolerance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Insomnia
- ☐ Palpitations
- ☐ Memory loss
- ☐ Nose bleeds
- ☐ Numbness/Tingling
- ☐ Seizures/Epilepsy
- ☐ Tremors
- ☐ Varicose veins

Earth:

- ☐ Acid reflux
- ☐ Abdominal Pain
- ☐ Cold/Canker sores
- ☐ Diabetes
- ☐ Excessive thirst/hunger
- ☐ Gas/Bloating
- ☐ Hemorrhoids
- ☐ Hypoglycemia
- ☐ Indigestion
- ☐ Insulin resistance
- ☐ Irritable when hungry
- ☐ Nausea/Vomiting
- ☐ Tired after eating
- ☐ Ulcers
- ☐ Worrisome

Metal:

- ☐ Acne
- ☐ Asthma
- ☐ Constipation
- ☐ Cough
- ☐ Despair/Apathy
- ☐ Diarrhea
- ☐ Eczema
- ☐ Emphysema
- ☐ Gingivitis
- ☐ Hay fever
- ☐ Hives
- ☐ Psoriasis
- ☐ Rashes/Itchiness
- ☐ Respiratory infections
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin tags
- ☐ Wheezing/Hoarseness

Water:

- ☐ Arthritis
- ☐ Chronic urinary tract infections
- ☐ Dentures
- ☐ Frequent ear infections
- ☐ Hair loss
- ☐ Hearing loss
- ☐ Kidney stones
- ☐ Low blood pressure
- ☐ Low libido

☐ Edema ☐ Incontinence ☐ PMS

☐ Excess libido ☐ Infertility ☐ Prostate issues

☐ Fearful ☐ Joint pain ☐ Ringing in ears

Women:

☐ Breast masses or cystic breasts ☐ Lack of periods (premenopause) ☐ Menopause (age) ___

☐ Hysterectomy ☐ Painful/Heavy periods ☐ Vaginal discharge

☐ Irregular periods ☐ Spotting ☐ Yeast infections

☐ Pregnancies #_____ ☐ Miscarriage #/date _____ ☐ C-section #_____

Are you/Do you plan to become pregnant? ☐Yes ☐No _____

Are you breastfeeding? ☐Yes ☐No _____

Are you taking birth control? What kind? ☐Yes ☐No _____

Are you on hormone replacement therapy? ☐Yes ☐No _____

Other:

☐ Autoimmune disease ☐ Hernia ☐ Relationship problems

☐ Bleeding gums ☐ History of abuse ☐ Restless legs

☐ Employment difficulties ☐ History of antibiotic use ☐ Schizophrenia

☐ Erectile dysfunction ☐ History of vaccine reactions ☐ Serious head injury

BLOOD WORK:

If you have recent blood work (within the last 6 months), please include a copy with this form. It is not required, but can be extremely helpful in understanding your full health picture.

INFORMED CONSENT:

I _____, hereby grant permission to receive a professional and complete health examination and consultation, including possible urinalysis and/or Nerve Express Heart Rate Variability. I request that Optimum Vitality provides me with dietary and/or nutritional recommendations as an aid in the management of my overall health. I understand that the counseling and procedures used at Optimum Vitality are to support balanced body chemistry and general well-being. I am fully aware that the dietary and/or nutritional recommendations, along with the in-office assessments including all instruments/software are not used to diagnose existing, or potential diseases of any kind. Any suggested nutritional program is not intended as primary therapy for any disease or symptom, but is an adjunctive schedule of nutrients (food concentrates) provided solely to upgrade the quality of foods in the diet. This will supply good nutrition for supporting the physiological and biochemical processes of the human body. I am also aware that these recommendations are designed only to supplement traditional methods of treatment, and that no guarantee is offered for the outcome of their use in the treatment of symptoms or conditions.

I understand that if I am on any medications, I have been advised to consult my prescribing physician in regards to dosage reduction and/or elimination of my medication(s) as my physiology may change while on this program. I also agree to remain compliant with the guidelines of the program.

Finally, I have read this form and/or had it fully explained to me, and I understand its content and significance. I also agree to receive appointment confirmation calls, texts, and/or emails at the number and email provided on the intake form.

Signature (client/parent/guardian):

_____

FINANCIAL AGREEMENT:

I, _____, agree to full financial responsibility for services rendered and products purchased. I understand that payment is required in full at time of service unless arrangements were agreed to in advance. Cash, check and credit card are the only accepted forms of payment at this time. Notice of 24 hours is necessary for cancelled and rescheduled appointments. I may be charged the cost of the visit for a missed appointment.

Signature (client/parent/guardian): Date:

_____ _____