pure nutrition+wellness LLC

inspiring you to take charge of your health naturally

CLIENT INTAKE FORM

Name: _____ Date: _____
Address: _____ Home #: _____
City/State/Zip: _____ Cell #: _____
Email: _____

Chief Complaint _____
Secondary Complaints _____
_____

Sex: _____ Height: _____ Weight: _____ Age: _____ DOB: _____

Single or Married: _____

Occupation: _____ Referred by: _____
Current Medications: _____
_____
Over the Counter Medications: _____
_____
Do you see a Physician for any current health issues? _____
If so please list _____
_____
_____
Supplements _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List all surgeries and dates _____
_____
_____

Any known allergies? _____

Any other aspects of your health history we should be aware of? _____
_____
_____

Please list diseases or conditions in your family history:

Grandmother: _____
Grandfather: _____
Mother: _____
Father: _____
Siblings: _____

What time do you normally go to bed? _____
What time do you wake up in the morning? _____
Do you wake up rested? _____
Do you sleep sound/without interruptions? _____

Describe your normal meals:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

List your normal day's intake of the following:

Water: _____ Alcohol: _____ Coffee/Tea: _____
Juice: _____ Soda: _____ Diet Drinks: _____

How often do you have a bowel movement? _____
Describe your energy level: _____
What is your favorite food? _____

Please note: The material presented by "Pure Nutrition + Wellness" is a result of personal study and experience. Donna Stephens is a Certified Natural Health Practitioner and not a licensed physician Pure Nutrition + Wellness does not engage in the diagnosis of disease or the prescription of any health program as a cure for disease. The material and resources offered by "Pure Nutrition + Wellness" is intended for educational purposes only. Be sure to consult with your personal physician regarding the treatment of any medical condition.

Client Signature: _____

Circle All Symptoms That Apply

Acne	Edema	Perspiration
ADD/ADHD	Emphysema	PMS
Adrenal glands	Epilepsy	Pneumonia
Allergies	Eyesight	Polyps
Alzheimer's	Fatigue	Pregnancy
Anemia	Fever	Prostate
Anger	Flu	Psoriasis
Anxiety	Gallstones	Rash
Appetite	Gangrene	Reproductive
Arteriosclerosis	Gas	Respiratory
Arthritis	Gout	Restless Leg
Asthma	Gums	Rheumatism
Back Pain	Thinning hair	Ring Worm
Bad Breath	Headache	Seizures
Bed Wetting	Heart issues	Shingles
Bell's Palsy	Heartburn	Sinus
Bites	Hemorrhoids	Skin issues
Bladder	Herpes	Snoring
Blood Pressure High	hernia	Sore throat
Blood Pressure Low	Hives	Stomach
Boils	Hormones	Stress
Bones	Hyperactive	Stroke
Breathing	Hypertension	Thyroid
Bronchitis	Hyperthyroidism	Tennis Elbow
Bruises	Hypoglycemia	Tonsillitis
Burns	Impotence	Tumor
Cancer	Incontinence	Ulcers
Candida	Indigestion	Urinary Infections
Canker Sores	IInsomnia	Varicose veins
Carpal Tunnel Syndrome	Joint Pain	Vertigo
Cataracts	Kidney Issues	Weight-overweight
Chest Congestion	Kidney Stones	Weight-underweight
Chest Pain	Leukemia	Yeast infections
Cholesterol	Liver	
Circulation	Lung issues	
Cold-Common	Lupus	
Cold-tempature	Lymph Glands	
Colic	Menopause	
Colon	Menstrual Cramps	
Constipation	Migraines	
Cough	Mononucleosis	Fibroid Tumors

Cravings	Mucus	Breast Tumors
Dandruff	Nails	Fainting
Depression	Nausea	Fibromyalgia
Diabetes	Nervousness	numbness in hands/feet
Diarrhea	Nose bleeds	Bleeding
Digestion	Parasites	Ovaries
Dizzy Spells	Parkinson’s Disease	Pancreas
Ear infections	TMJ	Pacemaker
Ear ringing	Dry Eyes	Shunt, Implant
	Bleeding gums	Burping/Gas
	Gum disease	

Other: _____

_____

_____