APPT. DATE: TIME:

REITER NUTRITION & HEALTHY LIVING
Client Intake Form

New Client/New Condition Referred By: _____

NAME: FIRST _____ MI _____ LAST _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

PHONE: HOME _____ CELL_____ WORK_____

SEX: M or F

HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: SINGLE MARRIED PARTNER SEPARATED DIVORCED WIDOWED

DATE OF BIRTH _____

EMAIL: _____

OCCUPATION: _____

SPOUSE OR PARENTS (if patient is a minor):

_____ D.O.B _____ EMPLOYER _____

_____ D.O.B _____ EMPLOYER _____

CHILDREN: YES or NO

If yes, what are their names and ages:

_____

_____

REASON FOR VISIT (please list in order of importance):

_____

_____

APPT. DATE: TIME:

DATE THE HEALTH CONCERN STARTED? _____

DO YOU KNOW WHAT MAY HAVE CAUSED YOUR HEALTH ISSUE? CIRCLE ALL THAT MAY APPLY:

TRAUMA/INJURY OTHER ILLNESS MAJOR LIFE CHANGE POOR DIET

HIGH STRESS MOVE/RELOCATION BIRTH CONTROL/CONTRACEPTIVES MOLD

SURGERY POOR LIFESTYLE HABITS TOXIC RELATIONSHIPS CHEMICALS

VACCINE ANTIBIOTIC USE PREGNANCY UNKNOWN

PLEASE ELABORATE HERE: _____

_____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? Circle YES or NO

WHEN?_____ WHO?_____

WHEN?_____ WHO?_____

HAVE YOU BEEN GIVEN ANY DIAGNOSIS? (Diabetes, PCOS, Hashimotos, etc.)

WHAT HAVE YOU DONE IN THE PAST AND CURRENTLY TO MANAGE IT? PLEASE LIST ANY SELF-CARE, DIETS, ETC.

PLEASE LIST ALL **MEDICATIONS** YOU ARE CURRENTLY TAKING, DOSE *AND* REASON FOR TAKING:

1.
2.
3.
4.
5.

(If you need more space, please attach a separate piece of paper)

APPT. DATE: TIME:

PLEASE LIST ALL **SUPPLEMENTS** YOU ARE CURRENTLY TAKING *AND* THE REASON FOR TAKING:

1.
2.
3.
4.
5

(If you need more space, please attach a separate piece of paper)

PLEASE LIST THE FOODS YOU COMMONLY EAT FOR EACH MEAL BELOW:

BREAKFAST:

LUNCH:

DINNER:

SNACKS

BEVERAGES:

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Are there any foods you crave?

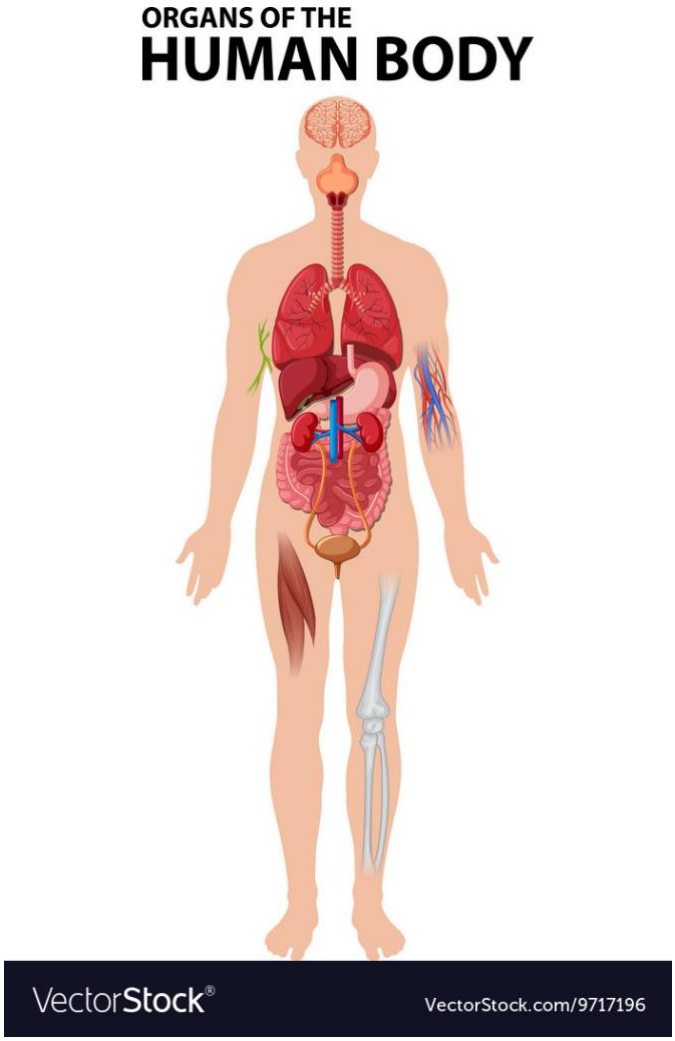
Any foods you really dislike?

Any known food allergies?

Do you experience seasonal allergies? Circle one YES or NO

Which do you do more often? Circle one COOK AT HOME GO OUT TO EAT/TAKE OUT

ON DIAGRAM, PLEASE CIRCLE AREAS AND SPECIFY WHERE YOU ARE EXPERIENCING ISSUES OR PAIN:



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HEALTH HISTORY:

SMOKER? Yes No Ex-Smoker

DRUG USE? Circle one YES or NO
Drug Name(s): _____
Circle one CURRENTLY or PAST USE
How long? _____

ALCOHOL USE: Circle one below

NEVER 1-2 DRINKS PER MONTH 3-4 DRINKS PER WEEK DAILY

ANY SURGERIES?

What? _____

When? _____

Any complications from those surgeries? Circle YES or NO
If yes, please explain:
_____
_____

ENERGY LEVELS

1. How do you feel when you wake up in the Morning? Circle or Underline one
   Struggle to get out of bed Ready to take on the day

2. How do you feel by the Afternoon? Circle or Underline one
   Have lots of energy Feel like you hit a wall and need a nap

SLEEP

1. Do you have any trouble falling asleep? Circle one YES or NO

2. Do you have any trouble staying asleep? Circle one YES or NO

3. How many hours of sleep do you get per night on average? _____

STRESS:

1. Are you carrying a lot of mental stress right now? Work? Home Life?

2. When you feel stressed, do you feel like you are handling it well? Or does it feel like it over takes you?

3. Do you have any relationships in your life that are causing you added stress?

4. Any other stressors you want to share with me at this time?

HEART:

1. Have you ever had a heart attack? Circle one YES or NO
2. Have you ever had a stroke? Circle one YES or NO
3. Do you have trouble with blood clotting? Circle one YES or NO
4. Do you experience heart palpitations? Circle one YES or NO

DENTAL:

1. Do you have amalgam (silver) fillings? Circle one YES or NO
2. Are you prone to cavities? Circle one YES or NO
3. Do you floss your teeth on a daily basis? Circle one YES or NO
4. Do you experience bleeding when you floss? Circle one YES or NO
5. Do you experience bad breath often? Circle one YES or NO

BIRTH EXPERIENCE:

1. Were you born VAGINALLY or C-SECTION? Circle one
2. Were you BREAST-FED or given FORMULA? Circle one
3. Were you born premature? Circle one YES or NO

CYCLES:

1. Do you have regular cycles? (About every 28 days)
2. How long do your menses last?
3. Do you experience Heavy or light bleeding, spotting, clotting, painful cramps, breast tenderness, mood swings, headaches/migraines, brain fog? Circle or list all that apply

4. Post menopause---Do you have any common menopausal symptoms? Hot flashes, weight gain, vaginal dryness, mood changes?
5. Do you have a healthy libido? Circle one YES or NO

BOWEL MOVEMENTS:

1. Do you have daily bowel movements? How many times a day?
2. Are they well formed, loose, hard?
3. What color are your stools? Brown tan gray black green
4. Do you experience any blood in your stools? Circle one YES or NO
5. Any Mucus? Circle one YES or NO
6. Do you see any bits of undigested food in your stools? Circle one YES or NO

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7. Do you have your gallbladder? Circle one YES or NO
8. Does your stool float or does it sink?
9. Do you experience any gas, bloating, diarrhea, constipations or cramping? Circle all that apply.
10. Do you experience any heart burn/acid reflux? Circle one YES or NO
11. Do you have any pain in your upper right abdomen where your liver and gallbladder are located? Circle one YES or NO

SKIN:

1. Do you have any acne, eczema, rosacea, psoriasis, bumps on skin or other rashes?
2. Do you have dry skin? YES NO

PAIN:

1. Do you have any pain in your joints OR anywhere in the body?
    a. Where?
    b. How long?

MOOD:

1. Do you get mood swings?
2. Do you generally have a happy, positive outlook on life or do you tend to dwell on what is going wrong in your life and feel unhappy?

ANXIETY:

1. Do you experience any anxiety?
2. Do you feel unsettled and stressed most of the time?
3. Do you have trouble focusing because your mind is going 100 miles a minute?

DEPRESSION:

1. Do you experience any depression?
2. How do you manage your depression?
    a. Do you isolate yourself?
    b. Do you seek help by talking to a friend or mental health professional?
    c. Work overtime?
    d. Do you take any medications to help you cope?
    e. Do you use drugs or alcohol to numb the pain?

BRAIN FOG:

1. Do you have trouble thinking clearly or quickly?

HEADACHES:

1. Do you get headaches? How frequently? DAILY 1-2 PER WEEK 1-4 PER MONTH

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FACIAL HAIR:

1. Do you have facial hair that you have to pluck or feels embarrassing? Hair loss? Male-pattern baldness? Hair around navel or nipples?

PREGNANCIES/MISCARRAGIES:

1. How many pregnancies have you had?
2. Any difficulties?
3. Any miscarriages? How many?

BIRTH CONTROL? YES NO

If Yes, was it in the past or currently? _____ How many years? _____

What form of birth control do/did you use? _____

MOLD:
Do you have any mold present in your home? (common places could be bathroom, basement, pillow, refrigerator, front-loading washer, etc.)

Have you had any breast implants? YES NO
If so, when? _____

- Reason for asking is because mold can grow within the implants and cause major health issues

PLEASE SHARE ANY OTHER INFORMATION YOU WOULD LIKE ME TO KNOW:
_____
_____
_____
_____
_____