New Client Intake Form

All information received on this form will be treated as strictly confidential. Please fill out the form ***completely and accurately***. This information is essential to helping the Carter Hall Lifestyle to develop a wellness program that addresses your needs, goals and interests and is safe and effective.

Demographics					
First Name		Middle Name		Last Name	
Preferred Pronouns	select one	Age		DOB	
Gender Identity	select one		Sex Assigned at Birth	select one	
Mailing Address					
City, State, Zip					
Preferred Phone					
Email Address					
Referred by					

Concerns
What health and/or nutrition concerns would you like to focus on during your visit?
1.
2.
3.

Medical History					
Please check “yes” for the health conditions that your doctor has diagnosed, and then record the approximate date of onset.					
Condition	**Yes**	**Date of Onset**	**Condition**	**Yes**	**Date of Onset**
GASTROINTESTINAL			INFLAMMATORY/ AUTOIMMUNE		
Irritable Bowel Syndrome	☐		Chronic Fatigue Syndrome	☐	
Inflammatory Bowel Disease	☐		Rheumatoid Arthritis	☐	
Crohn’s Disease	☐		Systemic Lupus	☐	
Ulcerative Colitis	☐		Graves’ Disease Erythematosus	☐	
Celiac Disease	☐		Hashimoto’s Thyroiditis	☐	
Gastric or Peptic Ulcer Disease	☐		Multiple Sclerosis	☐	
GERD, reflux/heartburn	☐		Sjogren’s syndrome	☐	
Food Intolerance	☐		Other:	☐	
Other:	☐				
RESPIRATORY			MUSCULOSKELETAL/ PAIN		
Asthma	☐		Osteoarthritis	☐	
Chronic Sinusitis	☐		Chronic pain	☐	
Sleep Apnea	☐		Fibromyalgia	☐	
Bronchitis or Emphysema	☐		Migraines	☐	
Other:	☐		Other:	☐	
CARDIOVACULAR			URINARY/ REPRODUCTIVE		
Heart Disease/ Heart Attack	☐		Kidney Stones	☐	
Stroke	☐		Urinary Tract Infections	☐	
Elevated Cholesterol	☐		Yeast Infection	☐	
Irregular Heart Rate	☐		Prostate Problem	☐	
High Blood Pressure	☐		Other:	☐	
Other:	☐				

NEUROLOGICAL/ BRAIN			METABOLIC/ ENDOCRINE		
Depression	☐		Type 1 Diabetes	☐	
Anxiety	☐		Type 2 Diabetes	☐	
Bipolar disorder	☐		Metabolic Syndrome	☐	
ADD/ ADHD	☐		Hypoglycemia	☐	
Multiple Sclerosis	☐		Hypothyroidism	☐	
Seizures	☐		Polycystic Ovarian Syndrome	☐	
Anorexia Nervosa	☐		Infertility	☐	
Bulimia	☐		Other:	☐	
Unspecified Eating Disorder	☐				
Parkinson's Disease	☐				
Other:	☐				
DERMATOLOGICAL			CANCER: Please list type(s) and treatments		
Eczema	☐				
Psoriasis	☐				
Acne	☐				
Other:	☐				

Additional health conditions your doctor has diagnosed:

Please list any previous injuries, surgeries, and hospitalization. Provide your age and date if known.

Family History "Blood Relative"

Have any of your close relatives (parent, sibling, child grandparent) been diagnosed with the following?
Please check, describe, and provide age of onset for those that apply.

Condition	Yes	Family Members(s)	Age of Onset	Description
Heart Disease	☐			
High Blood Pressure	☐			
Stroke	☐			
Diabetes	☐			
Cancer	☐			
Overweight	☐			
Food Intolerance	☐			
Autoimmune Disease	☐			

Oral History

Do you visit a dentist twice per year? ☐ Yes ☐ No

Do you have any silver/mercury amalgam fillings? ☐ Yes ☐ No If yes, how many?

Allergies		Allergic Symptoms Experience
Food		
Medication		
Supplement		
Environmental		

Medications and Supplements:

Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.

Medication Name	Year Started	Dose	Frequency	Reason
Herb/Supplement	**Year Started**	**Dose**	**Frequency**	**Reason**

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolong or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? ☐ Yes ☐ No

Have you taken antibiotics >3 times per year? ☐ Yes ☐ No

Have you been on antibiotic long term (>1 month continuously)? ☐ Yes ☐ No

Lifestyle Information

Do you engage in physical activity on a regular basis?

Activity	Number of Days per Week	Duration (minutes) per Session

How many hours do you sleep on weeknight? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+

How many hours do you sleep on weekends? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+

Check which apply to you: ☐ Trouble falling asleep ☐ Wake up during the night ☐ Don't feel rested

How do you handle stress? What helps you relax?

Environmental Exposures

What is your occupation?

Are you regularly exposed to any of the following?

☐ Cigarette smoke ☐ Paint fumes ☐ Perfumes ☐ Nail Polish

☐ Auto exhaust ☐ Chemicals ☐ Dry-cleaned clothes ☐ Hair dyes

Do you feel dizzy or get a headache when exposed to strong chemical odors or fumes? ☐ Yes ☐ No
If yes, please explain?

Please describe any significant past or present exposure to substances such as recreational drugs, alcohol, or chemicals.

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? ☐ Yes ☐ No

Have you changed your eating habits for a health reason? ☐ Yes ☐ No
Please describe.

Are you currently following a particular diet or nutrition plan? ☐ Yes ☐ No
Please describe.

Do you avoid any particular foods? ☐ Yes ☐ No
Please explain.

Nutrition History (continued)

Do you have any adverse food reactions (intolerances or allergies)? If yes, please explain.

Height:	Current Weight:	Usual Weight Range:

Have you recently lost or gained weight? ☐ Yes ☐ No If yes, please describe.

Do you have or have you had an eating disorder? ☐ Yes ☐ No If yes, please describe.

How many meals do you eat each day?	How many snacks do you eat each day?

How many meals do you buy from a restaurant or fast food **per week**? select one

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks **per week**? select one

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many cups **per day**? select one

Do you use any natural or artificial sweeteners? ☐ Yes ☐ No If yes, which ones?

What's your favorite meal?

Check all of the factors that apply to your eating habits and current lifestyle:

- ☐ Love to eat
- ☐ Love to cook
- ☐ Emotional eater
- ☐ Late night eater
- ☐ Struggle with eating issues
- ☐ Make poor snack choices
- ☐ Dislike cooking
- ☐ Fast Eater
- ☐ Erratic eating patterns
- ☐ Eat too much
- ☐ Rely on convenience foods
- ☐ Eat fast food frequently
- ☐ Negative relationship with food
- ☐ Limited cooking knowledge
- ☐ Live alone or eat alone often
- ☐ Do not plan meals or menus
- ☐ Time constraints
- ☐ Travel frequently
- ☐ Eat alone because I have to
- ☐ Confused about food/nutrition

Food Diary: Please record what you eat and drink during one typical day (24 hour period).
Please be sure to include all beverages, cream and sweetener added to beverages and condiments added to foods.

Time woke up:		Bedtime:	
Time	Food and Beverage Items	Amount (e.g. cups, oz, tsp)	Locations (Home/Away)

Food Frequency Questionnaire – How often do you eat the following?						
Food	**Never or <4x/yr.**	**Rarely or <4x/mo.**	**Once/wk**	**2x/wk**	**3x/wk**	**Daily**
Cheese	☐	☐	☐	☐	☐	☐
Yogurt, Kefir	☐	☐	☐	☐	☐	☐
Cow's Milk	☐	☐	☐	☐	☐	☐
Plant-based Milk – Indicate type:	☐	☐	☐	☐	☐	☐
Red Meat	☐	☐	☐	☐	☐	☐
Pork (pork loin, pork roast, pork chops, barbeque)	☐	☐	☐	☐	☐	☐
Processed Meat (sausage, bacon, lunch meat)	☐	☐	☐	☐	☐	☐
Chicken	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Cold Water Fish (striped bass, wild Alaskan salmon, herring, sardine, anchovies, mackerel, Alaskan halibut,	☐	☐	☐	☐	☐	☐
Other fish or shellfish – Indicate type:	☐	☐	☐	☐	☐	☐
Beans, Legumes (black beans, kidney beans, white beans, lentils)	☐	☐	☐	☐	☐	☐
Tofu, Tempeh	☐	☐	☐	☐	☐	☐
Plant-based Protein/Meat	☐	☐	☐	☐	☐	☐
Berries	☐	☐	☐	☐	☐	☐
Other Fruits – Indicate type:	☐	☐	☐	☐	☐	☐
Cruciferous Vegetables (cabbage, broccoli, Brussels sprouts)	☐	☐	☐	☐	☐	☐
Green Leafy Vegetables (e.g. spinach, kale, collard, greens)	☐	☐	☐	☐	☐	☐
Yellow Fruits and Vegetables (e.g. yellow peppers, corn)	☐	☐	☐	☐	☐	☐
Other Green Fruits and Vegetables: (e.g. peas, broccoli, avocado, cucumbers)	☐	☐	☐	☐	☐	☐
Blue/Purple Fruits and Vegetables (e.g. blueberries, prunes, beets, purple cabbage)	☐	☐	☐	☐	☐	☐
Red Fruits and Vegetables (e.g. cherries, apples, tomatoes, kidney beans)	☐	☐	☐	☐	☐	☐
Orange Fruits and Vegetables (e.g. orange, cantaloupe, carrots, sweet potato)	☐	☐	☐	☐	☐	☐
White/Tan Fruits and Vegetables (e.g. onions, garlic, ginger, nuts)	☐	☐	☐	☐	☐	☐
Turmeric, Cumin, Ginger, Rosemary, Oregano, Parsley	☐	☐	☐	☐	☐	☐
Nuts, Nut Butters – Indicate type:	☐	☐	☐	☐	☐	☐
Avocado, Extra Virgin Olive Oil, Canola Oil	☐	☐	☐	☐	☐	☐
Vegetable oil (corn, sunflower, safflower, etc.)	☐	☐	☐	☐	☐	☐
Butter, Ghee	☐	☐	☐	☐	☐	☐
White Rice or Pasta	☐	☐	☐	☐	☐	☐

Food	Never or <4x/yr.	Rarely or <4x/mo.	Once/wk	2x/wk	3x/wk	Daily
White Bread or Biscuits	☐	☐	☐	☐	☐	☐
Bagels	☐	☐	☐	☐	☐	☐
English Muffins	☐	☐	☐	☐	☐	☐
Whole Grains (oats, quinoa, brown/wild, barley, buckwheat, amaranth)	☐	☐	☐	☐	☐	☐
Plant-based Pasta	☐	☐	☐	☐	☐	☐
Pizza	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Pretzels	☐	☐	☐	☐	☐	☐
Popcorn	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐
Pastries, cookies, cakes	☐	☐	☐	☐	☐	☐
Other Snack Food – Indicate type:	☐	☐	☐	☐	☐	☐
Punch, Lemonade, or Sweet Tea	☐	☐	☐	☐	☐	☐
Diet Soda	☐	☐	☐	☐	☐	☐
Juice – Indicate type:	☐	☐	☐	☐	☐	☐
Soda (not diet)	☐	☐	☐	☐	☐	☐
Tea (white, green, black)	☐	☐	☐	☐	☐	☐
Wine or Champagne	☐	☐	☐	☐	☐	☐
Beer	☐	☐	☐	☐	☐	☐
Hard Liquor	☐	☐	☐	☐	☐	☐
Other Beverages – Indicate type:	☐	☐	☐	☐	☐	☐

Daily Intake Summary

What type(s) of protein do you consume most days of the week? Check all that apply.

☐ Plant-based meat ☐ Fish ☐ Chicken ☐ Beef ☐ Turkey ☐ Dairy products & Eggs ☐ Nuts and seeds

How many servings of fruit do you have in a day?	
How many servings of vegetables do you have in a day?	

Provide an estimate of the amount of each beverage that you consume on an average day. Please state in ounces

Water	Soda	Wine
Juice	Diet-soda	Beer
Tea	Energy drink	Cocktails