INTAKE FORM

Eat & Sleep in Peace: Wellness Consulting & EMF Solutions

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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