**Metabolic Fitness**

# Intake Form

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*Please take time to answer the following questions to the best of your knowledge. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

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## Client Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Referred by

## Statistics

**Age**

**Height (in inches)**

**Blood Type**

**Current Weight**

**Ideal Weight**

**Weight One Year Ago**

**Birth Weight (if known)**

**Birth Order (please list ages of biological siblings)**

| Sibling | Current Age |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Family/Living Situation**

**Children**

**Occupation**

**Exercise/Recreation**

## History

**Have you lived or traveled outside of the United States? If so, when and where?**

**Have you or your family recently experienced any major life changes? If so, please comment.**

**Have you experienced any major losses in life? If so, please comment.**

**How much time have you had to take off from work or school in the last year?**

- 0-2 days
- 3-14 days
- More than 15 days

# Health Information

**What is your primary health concern? (Describe in detail, including the severity of the symptoms).**

**When did you first experience these concerns?**

**Have you found anything to make your symptoms better or worse? Are there any other related symptoms?**

**Do you have any secondary health concerns you are looking to have addressed during your consultation? (Describe in detail)**

**What other health practitioners are you currently seeing? List name and specialty below.**

**Please list the date and description of any surgical procedures you have had (including cosmetic)..**

| Surgical Procedure | Date | Description |
|---|---|---|
| | | |
| | | |
| | | |

**How often did you take antibiotics in infancy/childhood, as a teen, and/or as an adult?**

**List any medicine you are currently taking.**

| Medicine Name | Dosage | Frequency / Route | Duration | Comments |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**List all vitamins, minerals, herbs and nutritional supplements you are now taking.**

| Name | Dosage | Frequency / Route | Duration | Comments |
|---|---|---|---|---|
| | | | | |
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**Have any other family members had similar problems (please describe)?**

## Nutritional Status

**Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and the symptom:**

**Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:**

**Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:**

**Are there foods that you crave? If so please explain:**

**Describe your diet at the onset of your health concerns:**

**Do you have any known food allergies or sensitivities?**

**Which of the following foods do you consume regularly?**

soda

fast food

- diet soda
- refined sugar
- alcohol
- gluten (wheat, rye, barley)
- dairy (milk, cheese, yogurt)
- coffee

**Are you currently on a special diet?**

- Autoimmune paleo (AIP)
- SCD/GAPS
- dairy restricted or dairy-free
- vegetarian
- vegan
- other (please describe below)
- paleo
- blood type
- raw
- refined sugar-free
- gluten-free

**If you checked "Other" from the question above, please describe in more detail here.**

**What percentage of your meals are home-cooked? Please describe.**

**Is there anything else we should know about your current diet, history or relationship to food?**

## Intestinal Status

**Bowel Movement Frequency**

- 1–3 times per day
- more than 3 times per day
- not regularly every day

**Bowel Movement Consistency**

- soft & well formed
- often float

difficult to pass
diarrhea
thin, long or narrow
small and hard
loose but not watery
alternating between hard and loose

**Bowel Movement Color**

medium brown
very dark or black
greenish
blood is visible
variable
yellow, light brown
chalky colored
greasy, shiny

**Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:**

**Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:**

# Medical Status

### Gastrointestinal

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Irritable Bowel Syndrome | | | | | |
| Crohn's | | | | | |
| Ulcertative Colitis | | | | | |
| Gastritis or Peptic Ulcer Disease | | | | | |
| GERD (reflux or heartburn) | | | | | |
| Celiac Disease | | | | | |
| SIBO | | | | | |
| Gut infections | | | | | |
| Dysbiosis | | | | | |
| Leaky gut | | | | | |
| Food allergies, intolerances or reactions | | | | | |
| Gallstones | | | | | |
| Known absorption or assimilation issues | | | | | |
| Other | | | | | |

### Cardiovascular

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Heart attack | | | | | |
| Heart Disease | | | | | |
| Stroke | | | | | |
| Elevated cholesterol | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Arrhythmia (irregular heartbeat** | | | | | |
| **Hypertension (high blood pressure)** | | | | | |
| **Rheumatic Fever** | | | | | |
| **Mitral Valve Prolapse** | | | | | |
| **Other** | | | | | |

### Hormones/Metabolic

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| **Type 1 Diabetes** | | | | | |
| **Type 2 Diabetes** | | | | | |
| **Type 2 Diabetes** | | | | | |
| **Metabolic Syndrome** | | | | | |
| **Insulin Resistance or Pre-Diabetes** | | | | | |
| **Hypothyroidism (low thyroid)** | | | | | |
| **Hyperthyroidism (overactive thyroid)** | | | | | |
| **Hashimoto's (autoimmune hypothyroid)** | | | | | |
| **Grave's Disease (autoimmune hyperthyroid)** | | | | | |
| **Endocrine problems** | | | | | |
| **Polycystic Ovarian Syndrome (PCOS)** | | | | | |
| **Infertility** | | | | | |
| **Weight gain** | | | | | |
| **Weight loss** | | | | | |
| **Frequent weight fluctuations** | | | | | |
| **Eating disorder** | | | | | |
| **Menopause difficulties** | | | | | |

| Hair loss | | | | | |
|---|---|---|---|---|---|
| Other | | | | | |

### Cancer

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Lung Cancer | | | | | |
| Breast Cancer | | | | | |
| Colon Cancer | | | | | |
| Ovarian Cancer | | | | | |
| Prostate Cancer | | | | | |
| Skin Cancer (Melanoma) | | | | | |
| Skin Cancer (Squamous, Basal) | | | | | |
| Other | | | | | |

### Genital & Urinary Systems

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Kidney Stones | | | | | |
| Gout | | | | | |
| Erectile Dysfunction or Sexual Dysfunction | | | | | |
| Interstitial Cystitis | | | | | |
| Frequent urinary tract infections | | | | | |
| Frequent Yeast Infections | | | | | |
| Other | | | | | |

**Musculoskeletal/Pain**

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Osteoarthritis | | | | | |
| Fibromyalgia | | | | | |
| Chronic Pain | | | | | |
| Sore muscles or joints, undiagnosed | | | | | |
| Other | | | | | |

**Immune/Inflammatory**

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Chronic Fatigue Syndrome | | | | | |
| Rheumatoid Arthritis | | | | | |
| Lupus SLE | | | | | |
| Raynaud's | | | | | |
| Psoriasis | | | | | |
| Mixed Connetive Tissue Disease (MCTD) | | | | | |
| Poor immune function (frequent infections) | | | | | |
| Food allergies | | | | | |
| Environmental allergies | | | | | |
| Multiple chemical sensitivities | | | | | |
| Latex allergy | | | | | |
| Hepatitis | | | | | |
| Lyme (and co-infections) | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, etc.)** | | | | | |
| **Other** | | | | | |

**Respiratory Conditions**

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| **Asthma** | | | | | |
| **Chronic Sinusitis** | | | | | |
| **Bronchitis** | | | | | |
| **Emphysema** | | | | | |
| **Pneumonia** | | | | | |
| **Sleep Apnea** | | | | | |
| **Frequent or recurrent Colds/Flus** | | | | | |
| **Other** | | | | | |

**Skin Conditions**

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| **Eczema** | | | | | |
| **Psoriasis** | | | | | |
| **Dermatitis** | | | | | |
| **Hives** | | | | | |
| **Rash, undiagnosed** | | | | | |
| **Acne** | | | | | |
| **Skin Cancer (Melanoma)** | | | | | |
| **Skin Cancer (Squamous, Basal)** | | | | | |
| **Other** | | | | | |



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### Neurologic/Mood

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Depression | | | | | |
| Anxiety | | | | | |
| Bipolar Disorder | | | | | |
| Schizophrenia | | | | | |
| Headaches | | | | | |
| Migraines | | | | | |
| ADD/ADHD | | | | | |
| Autism | | | | | |
| Mild Cognitive Impairment | | | | | |
| Memory problems | | | | | |
| Memory problems | | | | | |
| Multiple Sclerosis | | | | | |
| ALS | | | | | |
| Seizures | | | | | |
| Alzheimer's | | | | | |
| Other | | | | | |

### Miscellaneous

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

| Condition | Symptoms | Chosen Treatment(s) | Dates | Past | Now |
|---|---|---|---|---|---|
| Anemia | | | | | |
| Chicken Pox | | | | | |
| German Measles | | | | | |
| Measles | | | | | |
| Mononucleosis | | | | | |
| Mumps | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Sleep Apnea** | | | | | |
| **Whooping Cough** | | | | | |
| **Tuberculosis** | | | | | |
| **Known genetic variants (SNPs, polymorphisms, etc)** | | | | | |
| **Other** | | | | | |

**Please check frequency of the following:**

| | Yes | No | Sometimes |
|---|---|---|---|
| **Short term memory impairment** | | | |
| **Shortened focus of attention and ability to concentrate** | | | |
| **Coordination and balance problems** | | | |
| **Problems with lack of inhibition** | | | |
| **Poor organization abilities** | | | |
| **Problems with time management (late or forget appts)** | | | |
| **Mood instability** | | | |
| **Difficulty understanding speech and word finding** | | | |
| **Brain fog, brain fatigue** | | | |
| **Lower effectiveness at work, home or school** | | | |
| **Judgment problems like leaving the stove on, etc** | | | |

## Health Hazards

**Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?**

**Do odors affect you?**

**Are you or have you been exposed to second-hand smoke?**

## Oral Health History

**In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)**

**What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)**

**Do you have any concerns about your oral or dental health? Such as having bleeding gums, the presence or removal of mercury amalgams, etc?**

## Lifestyle History

**Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time**

**Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?**

**Do you have any other unhealthy habits (physical, mental, or emotional)?**

## Sleep History

**On average, how many hours do you sleep?**

**What time do you go to sleep at night?**

**Do you fall asleep in less than 30 minutes?**

**Are you satisfied with your sleep? Do you feel rested when you wake and that you have plenty of energy during the day?**

## For Women Only

**How old were you when you first got your period?**

**How are/were your menses? Do/did you have PMS? Painful periods? If so, explain**

**In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?**

**Have you experienced any yeast infections or urinary tract infections? Are they regular?**

**Have you/do you still take birth control pills: If so, please list length of time and type**

**Have you had any problems with conception or pregnancy?**

**Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.**

## Sexual History

**Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?**

## Psychosocial History

**Briefly outline a typical weekday. What do you do from waking to sleeping?**

| Time | Activity | Time | Activity |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please rate 1-10, how important these things are in your life**

| | |
|---|---|
| Career | |
| Fun & Recreation | |
| Money | |
| Family & Friends | |
| Health | |
| Physical Environment | |
| Romance | |
| Personal Growth | |

**How are your moods in general? Do you experience more anxiety, depression or anger than you would like?**

## Stress

**List the two most significantly stressful events in your life, from recent to most distant. Include the date of occurrence and whether it still impacts you.**

**On a scale of 1-10, one being low and 10 being high, what is the level of stress you are currently experiencing in your life?**

1 2 3 4 5 6 7 8 9 10

*1 = low, 10 = high*

**How do you handle stress?**

## Motivation and Health Goals

**What do you hope to achieve with your consultation?**

**Though it may seem odd, please consider why you might want to achieve that for yourself**

**At what point in your life did you feel best? Why?**

**When is the last time you felt well?**

**Did something trigger your change in health?**

**What do you think is happening and why?**

**What do you feel needs to happen for you to get better?**

**How motivated are you on a scale of 1 (unmotivated) to 5 (very motivated) to make changes to your diet, take supplements, exercise, and make lifestyle changes? Answer each individually.**

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