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Holistic Blooms LLC

SUBMIT FORM

RESET FORM

Client Intake Form

Please return at least 36 hrs before appointment

NAME: _____ DOB:_____

ADDRESS: _____

PHONE: _____ EMAIL: _____

TOP 3 HEALTH COMPLAINTS:

1. _____

_____

2. _____

_____

3. _____

_____

NUTRITIONAL DATA:

How many ounces of water/day? _____ What kind? _____

What other beverages and how much?_____

Do you use artificial sweeteners? Y ☐ N ☐ If so, which ones? _____

Do you eat breakfast? Y ☐ N ☐ If so, what?_____

How much of each do you consume?

(Example: 1D = 1/day, 2W = 2/week, 3M = 3/month)

Fresh fruit: _____ Raw vegetables: _____ Cooked vegetables: _____

Fermented foods: _____ Red meat: _____ Poultry: _____ Pork: _____

Fish: _____ Eggs: _____ Dairy: _____ Bread: _____ Fast Food: _____

What do you crave? _____

What foods do you dislike the most? _____ Why? _____

TIMING:

What is the first thing you do when you get up in the morning? _____

What time do you eat your first meal? _____ Last meal? _____

Which meal is your largest of the day? _____

Name: _____

How many hours of TV/Screen time do you get daily? _____ Me time? _____

MOVEMENT:

Do you exercise/move/participate in any fun sweaty activities? Y ☐ N ☐

If so, what, and how often? _____

Do you look forward to it? Y ☐ N ☐

How do you feel when you are finished? _____

SLEEP:

What time do you go to bed? _____ How long do you sleep? _____

Do you wake up often? Y ☐ N ☐

If so, why and at what time(s)? _____

Do you feel rested when you wake up for the day? Y ☐ N ☐

Do you have pain when you first get up? Y ☐ N ☐

If so, where? _____

Does it go away upon moving? Y ☐ N ☐

ELIMINATIONS:

Do you have daily bowel eliminations? Y ☐ N ☐ If yes, how many per day? _____

If no, please describe your elimination pattern. _____

Please indicate the most descriptive number(s) of your elimination(s) using the Bristol Stool chart below. _____ Color: _____

MEDICAL HISTORY:

Have you had any surgeries? Y ☐ N ☐

If so, what and when? _____

Have you received any diagnoses from licensed medical professionals? Y ☐ N ☑

If so, what and when? _____

Name: _____

CURRENT STRESS LEVELS:

Rate each area on a scale from 1-10 (1=very low stress, 10=maximum stress)

Rate the current level of personal stress in your life: ____

Rate the current level of relationship stress in your life:____

Rate the current level of health stress in your life: ____

Rate the current level of family stress in your life: ____

Rate the current level of occupational stress in your life: ____

How do you manage the stress in your life? _____

REVIEW OF SYSTEMS:

Y=current issue N=never been an issue P=past issue

SKIN:	Y	N	P		Y	N	P
Rash:	☐	☐	☐	Color Change:	☐	☐	☐
Lump:	☐	☐	☐	Warts/moles:	☐	☐	☐
Dry:	☐	☐	☐	Hives:	☐	☐	☐
Psoriasis/Eczema:	☐	☐	☐	Itchy:	☐	☐	☐
Cancer:	☐	☐	☐	Perspiration:	☐	☐	☐

HEAD:	Y	N	P		Y	N	P
Headache:	☐	☐	☐	Migraine:	☐	☐	☐
Dandruff:	☐	☐	☐	Head Injury:	☐	☐	☐
Oily/dry hair:	☐	☐	☐	Hair loss:	☐	☐	☐

NOSE:	Y	N	P		Y	N	P
Frequent Colds:	☐	☐	☐	Nosebleeds:	☐	☐	☐
Congestion:	☐	☐	☐	Postnasal Drip:	☐	☐	☐
Polyps:	☐	☐	☐	Seasonal Allergies:	☐	☐	☐

EYES:	Y	N	P		Y	N	P
Dry/Watery:	☐	☐	☐	Blurry Vision:	☐	☐	☐
Double Vision:	☐	☐	☐	Cataracts:	☐	☐	☐
Glaucoma:	☐	☐	☐	Sties:	☐	☐	☐
Strain:	☐	☐	☐	Discharge:	☐	☐	☐
Itchy:	☐	☐	☐	Dark under Eyes:	☐	☐	☐

MOUTH/THROAT:	Y	N	P		Y	N	P
Canker sores:	☐	☐	☐	Cold sores:	☐	☐	☐
Sore Throat:	☐	☐	☐	Gum disease:	☐	☐	☐
Dentures:	☐	☐	☐	Cavities:	☐	☐	☐
Dental Implants:	☐	☐	☐	Root Canals:	☐	☐	☐
Loss of taste:	☐	☐	☐	Hoarseness:	☐	☐	☐

Name: _____

NECK:	Y	N	P		Y	N	P
Stiffness:	☐	☐	☐	Swollen Glands:	☐	☐	☐
Full movement:	☐	☐	☐	Tension:	☐	☐	☐

RESPIRATORY:	Y	N	P		Y	N	P
Wheezing:	☐	☐	☐	Painful breathing:	☐	☐	☐
Shortness of breath lying down:	☐	☐	☐				

CARDIOVASCULAR:	Y	N	P		Y	N	P
High Blood Pressure:	☐	☐	☐	Rheumatic Fever:	☐	☐	☐
Low Blood Pressure:	☐	☐	☐	Murmurs:	✔	☐	☐
Arrhythmias:	☐	☐	☐	Palpitations:	☐	☐	☐
Edema:	☐	☐	☐	Chest Pain:	☐	☐	☐

URINARY TRACT:	Y	N	P		Y	N	P
Incontinence:	☐	☐	☐	Pain w/ Urination:	☐	☐	☐
Frequent Infections:	☐	☐	☐	Kidney Stones:	☐	☐	☐
Urgency:	☐	☐	☐	Discharge/Blood:	☐	☐	☐

GASTROINTESTINAL:	Y	N	P		Y	N	P
Heartburn:	☐	☐	☐	Indigestion:	☐	☐	☐
Recent BM Change:	☐	☐	☐	Bloating:	☐	☐	☐
Diarrhea/Constipation:	☐	☐	☐	Nausea:	☐	☐	☐
Hemorrhoids:	☐	☐	☐	Vomiting:	☐	☐	☐
Gall Bladder Disease:	☐	☐	☐	Change in Appetite:	☐	☐	☐
Ulcer:	☐	☐	☐	Liver Disease:	☐	☐	☐
Pancreatitis:	☐	☐	☐				

MALE:	Y	N	P		Y	N	P
Testicular pain/swelling:	☐	☐	☐	Sexually Active:	☐	☐	
Hernia:	☐	☐	☐	STD:	☐	☐	☐
Discharge:	☐	☐	☐	Impotency:	☐	☐	☐
Pain/swelling:	☐	☐	☐	Prostate Disease/ Symptoms:	☐	☐	☐

FEMALE:

Age Period Began: _____ How Often Period Occurs: _____

How long period lasts: _____ Heavy menstrual bleeding: Y ☐ N ☐

Menstrual cramping: Y ☐ N ☐ Menstrual Pain: Y ☐ N ☐

PMS: Y ☐ N ☐ Food cravings: Y ☐ N ☐

Last Pap Smear: _____ Any abnormal pap: Y ☐ N ☐

Results: _____

How many:

Pregnancies: _____ Births: _____

Miscarriages: _____ Abortions: _____

Name: _____

Sexually Active: Y ☐ N ☐ Pain w/ Intercourse: Y ☐ N ☐

Vaginitis: Y ☐ N ☐ STD: Y ☐ N ☐

Mammography: Y ☐ N ☐ Bone Density Test: Y ☐ N ☐

If yes, what were results: _____

Birth Control History:

Type(s) and ages when used: _____

Thermography: Y ☐ N ☐

If yes, what were results: _____

MUSCULOSKELETAL:	Y	N	P		Y	N	P
Weakness:	☐	☐	☐	Arthritis:	☐	☐	☐
Stiffness:	☐	☐	☐	Leg Cramps:	☐	☐	☐
Tremors:	☐	☐	☐	Pain:	☐	☐	☐

NERVOUS:	Y	N	P		Y	N	P
Paralysis:	☐	☐	☐	Sciatica:	☐	☐	☐
Tingling/numbness:	☐	☐	☐	Carpal tunnel:	☐	☐	☐
Seizures:	☐	☐	☐	Fainting:	☐	☐	☐

MENTAL/EMOTIONAL:	Y	N	P		Y	N	P
Depression:	☐	☐	☐	Anger:	☐	☐	☐
Suicidal:	☐	☐	☐	Irritability:	☐	☐	☐
Tense:	☐	☐	☐	High-strung:	☐	☐	☐
Fear:	☐	☐	☐	Anxiety:	☐	☐	☐
Eating disorder:	☐	☐	☐	Panic:	☐	☐	☐
Fainting:	☐	☐	☐	Psych Hospitalization:	☐	☐	☐

HISTORY OF ABUSE:	Y	N	P
Sexual:	☐	☐	☐
Physical abuse:	☐	☐	☐

NATUROPATHIC HISTORY:

Have you ever been in consultation with a naturopath? Y ☐ N ☐

If so, why? How long ago? _____

What was suggested?_____

Name: _____

Did you experience a good outcome? _____

What did you like about it? _____

What wasn't as successful for you?_____

Do you have regular adjustments with a chiropractor? Y☐ N☐

Do you have regular bodywork/massages? Y☐ N☐

Are you familiar with:

Homeopathy Y☐ N☐

Bach Flowers/flower remedies Y☐ N☐

Probiotics Y☐ N☐

Aromatherapy Y☐ N☐

Herbals Y☐ N☐

Enzymes Y☐ N☐

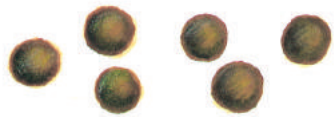
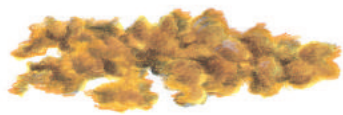
Spiritual/Biblical Coaching Y☐ N☐

Rate your willingness to make lifestyle changes on a scale from 1-10

1=not willing/10=extremely willing ☐

Signature: _____ Date: _____

The Bristol Stool Form Scale

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID