Nicole Weigl, ND
a natural approach to health

New Client Intake Form

Personal Information

Name_____Age_____Date of Birth___/___/____Sex: F M

Phone:_____Address:_____

Occupation_____Employer_____

How did you hear about me_____

Primary health concerns in order of importance:

1._____

2._____

3._____

4._____

Your health goals (i.e desired outcome of us working together) in order of importance:

1._____

2._____

3._____

4._____

Medical History

When did you last receive healthcare?_____

What was the reason_____

Preventative screenings. When was your last:

Blood Work_____

Was anything abnormal?_____

Eye exam_____

Dental exam_____

Colonoscopy_____ Was it normal: Y N

DEXA (Bone density) scan_____ Was it normal: Y N

Pap exam (women only)_____Was it normal: Y N

Mammogram exam (women only)_____Was it normal: Y N

Prostate exam (men only)_____Was it normal: Y N

Allergies:

To Medications_____

To Foods_____

Environmental_____

Past surgeries and/or hospitalizations:

1._____Date_____
2._____Date_____
3._____Date_____
4._____Date_____

Medications you are taking with dosage:

1._____
2._____
3._____
4._____
5._____

Supplements you are taking with *brand* and *dosage*:

1._____
2._____
3._____
4._____
5._____

Social History

How much water do you drink per day_____

Coffee in cups per day and time of day_____Soda in ounces_____

Use of the following: write **C** for current use and **P** for past use

Alcohol_____Drinks per week_____

Recreational drugs_____Frequency_____

Tobacco products_____Frequency_____

Sleep:

What time do you go to bed_____and wake up_____

Total hours per night_____

Circle all that apply:

No problems with sleep	Wakes refreshed
Difficulty falling asleep	Difficulty staying asleep
Waking un-refreshed	Number of times you wake____

Energy: Rate your energy: please circle

lowest 0 1 2 3 4 5 6 7 8 9 10 highest

Is your energy where you want it to be? YES NO

What is your best time of the day?_____Worst?_____

Exercise frequency per week_____Type_____

Stress:

Number of hours you work per week_____

Number of hours you relax or have fun per week_____

Do you consider your stress: (circle which applies)

Nonexistent Mild Moderate Severe Debilitating

What is your primary source of stress?_____

What do you do to manage stress_____

Digestion:

How often do you have a bowel movement?_____

Circle any that apply to bowel movements:

Undigested food Mucous Blood Painful Urgent

Circle any that are a current concern to you:

Constipation	Diarrhea	Gas/bloating
Abdominal pain	Hemorrhoids	IBS

Family History

Please indicate any known health condition. If applicable, age at death and reason:

Mother_____

Maternal grandmother_____

Maternal grandfather_____

Father_____

Paternal grandmother_____

Paternal grandfather_____

Siblings_____

Review of Systems

Next to the following symptoms circle **C** for currently experiencing, **P** for past or leave it blank if it has never affected you:

Headaches: C P

Dizziness: C P

Frequent ear infections: C P

Recurrent sinus infections: C P

Recurrent UTIs: C P

Asthma: C P

Heart disease: C P

High blood pressure: C P

High Cholesterol: C P

Anemia: C P

Hypothyroid: C P

Hyperthyroid: C P

Autoimmune disease: C P

Diabetes: C P

Cancer: C P

IBS or IBD: C P

Constipation: C P

Diarrhea: C P

Heartburn: C P

Anxiety: C P

Depression: C P

Eating disorder: C P

Low libido: C P

Other_____

Any thing else you'd like to tell me about you or your health?