Name_____ Date_____

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New Client Registration Form
All information on this form is confidential. If you are uncomfortable answering any questions, or if they do not apply you may leave them blank and discuss them with your practitioner.
Full Name _____ (print clearly please)
Gender Identity _____
Date of Birth_____ Time of Birth_____
Home Phone_____ Cell Phone _____ Work Phone _____
Address _____

Emergency Contact_____
Who referred you here? _____
Do you have children?_____ How Many?_____

How was the pregnancy and birth? _____

How was your pregnancy and birth for your mother and you?
_____

_____

ALLERGIES:

HEALTH CONCERNS (LIST IN ORDER OF IMPORTANCE)
1.
2.
3.
4.
5.
WHAT ARE YOUR SPIRITUAL, EMOTIONAL and/or HEALTH GOALS?

_____

_____

_____

CHILDHOOD DISEASES

GERMAN MEASLES__	RHEUMATIC FEVER__	STREP THROAT__
CHICKEN POX__	MEASLES __	MUMPS__
MONO___	OTHER__	

Name_____ Date_____

Name:_____ _____
Date:_____

Please indicate your level of satisfaction with the following areas in your life:
(1 is low and 10 is highest)

Phyisical / Environment____ Health____ Fun & Recreation___ Money___
Romance / Significant Other ___ Career ___ Friends / Family___ Personal Growth___

DIETARY HABITS:
Please list below typical foods you consume on a regular basis
Do you have a regular routine around eating? yes___ no___
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Fluids: _____
Any food cravings - Please list _____
How is your appetite? None___ Weak___ Normal___ Strong___ Irregular___
How does food affect you? Satisfied/Energized___ Unsatisfied/still hungry___ Fatigued/Sleepy___
Is your thirst: Extreme___ Changeable___ No thirst___ Dry Mouth___
Which tastes do you prefer? Sweet___ Sour___ Salty___ Pungent___ Bitter___ Astringent___
Please describe if you are following a special diet _____
_____
How many glasses of water do you consume each week? _____
How often do you eat breakfast each week? _____

DAILY Routines

	Time	**Routine (how often)**	**Activity**	**Variation**	**Spiritual Practice**	**Exercise**
Morning						
Mid-morning						
Lunch						
Mid-afternoon						
Evening						
Late-Evening						
Sleep Patterns						

DIRECTIONS FOR COMPLETING THE QUESTIONNAIRE: Rate the following symptoms based upon your typical health profile for the last 30 days. Use the following "Point Scale":
0= **Never or almost never** have the symptoms 1= **Occasionally** have symptom, effect is **NOT severe** 2= **Occasionally** have symptom, effect is **severe** 3= **Frequently** have symptom, effect is **NOT severe** 4= **Frequently** have symptom, effect is **severe**
Be sure to add the points up for each individual group of symptoms. At the end of the questionnaire, don't forget to tally the "GRAND TOTAL" of all of the symptom groups.

Name_____ Date_____

HEAD/NEUROLOGIC	**0**	**1**	**2**	**3**	**4**
Headache					
Faintness /Dizziness/Vertigo	0				
Epilepsy/Seizures/Convulsions	0				
Problems with Speech/Slurred Speech	0				
Other					
				Total	
EYES	**0**	**1**	**2**	**3**	**4**
Watery/ Itchy eyes					
Floaters					
Swelling					
Reddened or Sticky Eyelids					
Discharge					
Blurred Vision					
Eye Pain					
Dry Eyes					
Poor Night Vision					
Double Vision or Tunnel Vision					
Contact Lenses/Corrective Lenses					
Other					
					Total
EARS	**0**	**1**	**2**	**3**	**4**
Ear Infections					
Drainage from Ears					
Itchy Ears	1				
Ringing in Ears					
Earaches/Pain					
Hearing Loss/Problems					
Other					
					Total
NOSE	**0**	**1**	**2**	**3**	**4**
Nasal Congestion/Post Nasal Drip					
Frequent Infections					
Sneezing Attacks					
Bleeding					
Other					
				Total	
MOUTH/THROAT	**0**	**1**	**2**	**3**	**4**
Canker or Cold Sores					
Root Canals/Amalgams/Implants/Decay					
Bleeding Gums/Gum Problems Hoarseness/Voice Changes					
Frequent Sore Throat					
Hoarseness/Voice Changes					
Other					

Name_____ Date_____

	Total
SKIN 0 1 2 3 4	
Eczema /Dry Skin/Itching	
Rashes/Sores hives	
Acne/ Rosacea	
Hair Loss/Dryness or Changes	
Nail Dryness or Changes	
Hot Flashes/ Flushing	
Excessive Sweating	
Dark Circles Under Eyes	
Easy Bruising /Jaundice	
Other	
	Total 0
RESPIRATORY 0 1 2 3 4	
Chronic Cough	
Asthma/Wheezing	
Bronchitis/Pneumonia	
Difficulty breathing /Shortness of breath	
Other	
	Total
CARDIOVASCULAR 01 2 3 4	
Palpitations/Irregular Heartbeat/Arrythmias	
Chest Pain	
Heart Murmur	
Heart Attack (age:)	
Stroke (age:)	
Swelling of Hands/Feet/Legs/ Fluid retention	
Blood Clots in lungs or legs / Varicose Veins	
Pacemaker	
Other	**Total**
GASTROINTESTINAL 0 1 2 3 4	
Nausea/Vomiting	
Difficulty or Pain with Swallowing	
Diarrhea	
Constipation	
Bloating/Gas	
Indigestion/Heartburn/Reflux	
Pain or cramping with Digestion	
Loss/Excess Appetite	
Anal Discomfort	
Hemorrhoids	
Blood, Mucus or undigested food in Stool	
Black Tarry or “coffee ground” Stools	
Gallbladder or Liver Disease	
Hepatitis- Type:	
Diverticulitis/Colitis/Crohn’s	
Ulcer	
Other	
	Total

Name_____ Date_____

SYMPTOMS	**0**	**1**	**2**	**3**	**4**
MUSCULOSKELETAL					
Joints: Pain/Aches/Stiffness					
Limitation of Movement					
Muscles: Pain/Aches/Spasm/Strain					
Weakness					
Back Problems					
Osteoporosis/Osteopenia					
Broken Bones					
Trauma/Swelling					
Other					
					Total
ENDOCRINE	**0**	**1**	**2**	**3**	**4**
Thyroid Disease/Goiter					
Cold/Heat Intolerance					
Cold Hands and Feet Diabetes					
Diabetes					
Sweats/Night Sweats/Excessive Thirst night sweats					
Hormone Therapy					
Other					
					Total
ALLERGY/IMMUNITY	**0**	**1**	**2**	**3**	**4**
Hay Fever/Asthma/Eczema					
Drug Allergies					
Food Allergies					
Environmental/Animal Allergies					
Autoimmune Disease					
Cancer/Chemotherapy					
HIV/AIDS					
Other					
					Total
BLOOD/LYMPHATIC	**0**	**1**	**2**	**3**	**4**
Anemia					
Bleeding Tendencies					
Blood Transfusions					
Swollen Lymph Nodes					
Blood/ Lymph Disease or Cancer					
Other					
					Total
ENERGY/ACTIVITY	**0**	**1**	**2**	**3**	**4**
Fatigue					
Sluggishness					
Apathy					
Lethargy					

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Hyperactivity
Restlessness
Other
Total
PSYCHOLOGICAL/EMOTIONS 0 1 2 3 4
Anxiety/Fear/Nervousness/Panic Attacks
Depression/Sadness
Difficulty in Comprehension/Concentration/Making Decisions
Anger/Irritability/Aggressiveness
Mood Swings/Changes
Phobias
Alcohol/Chemical Dependency
Other
Total 0
Weight 0 1 2 3 4
Overweight/Underweight difficulty losing weight
Food cravings
Eating Disorders
Binge eating/drinking
Difficulty gaining weight
Other
Total
IMMUNIZATION HISTORY DATE BOOSTERS
Tetanus-Diphtheria (Tdap)
Measles-Mumps-Rubella (MMR)
Varicella
Hepatitis A
Hepatitis B
Flu Shot
Other
Please include any other pertinent information about your personal history that was not covered in this questionnaire. Use the back if necessary.

Name_____ Date_____

STRESS 0 1 2 3 4
What is most stressful in your life?

Are you seeing any healthcare providers? Please list all and why you are seeing them. Use the back of the page if necessary.

Please list all protocol, medications, supplements and herbs you are currently taking. Include dosages.

Please see next page for the next part of the intake form. Thank you.

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	QUALITY	Doesn't Apply	Somewhat	Applies
1.	My lifelong tendency has been to be thin and lanky			
2.	I find having a routine in life to be challenging			
3.	My skin tends to be rough and dry, even if I don't live in a dry, arid climate (but especially if I do)			
4.	My joints are fairly prominent			
5.	My teeth are protruded and/or crooked			
6.	My hair is kinky, curly and tends to be dry or frizzy			
7.	It is usually easy for me to lose weight and I usually have difficulty gaining weight			
8.	Usually in my life I enjoy hot weather			
9.	I tend to dislike wind			
10.	I tend to dislike dry			
11.	I have a medium build with medium bone structure			
12.	I enjoy competitive activities and enjoy physical or intellectual challenges			
13.	My teeth are medium-sized and/or a little yellow (stained doesn't count)			
14.	I have fair skin which easily sunburns			
15.	I have a lot of moles or freckles			
16.	I am or am becoming bald, I have grayed early, or I have thin or fine hair			
17.	Chili peppers, tomatoes and spicy food in general tends to cause me digestive distress, including heartburn or stomachache or loose stools, (even if I really enjoy the taste and am attracted to these things)			
18.	I prefer a cool climate to a warm one			
19.	I dislike heat, especially humid heat and feel easily fatigued by it			
20.	I have a sharp, intelligent, aggressive mind			
21.	I have a sturdy constitution with a large bone structure			
22.	I have had a lifelong tendency to always be at least a little overweight			
23.	My teeth are naturally large, straight and white			
24.	My hair is a thick and lustrous			
25.	My eyes are large and luxurious			
26.	If given the opportunity, I can easily sleep deeply for 8-10 hours per night			
27.	I gain weight easily and have difficulty losing weight			
28.	I tend to have excess mucous			

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29. I tolerate most climates well but usually in my life I have preferred hot, dry weather

30. My energy and stamina are consistent. When I have a lot to do I do it at a pace that I can maintain for a long time

Thank you for completing this questionnaire. Please be sure to print it out and bring it with you to your appointment.

What was your childhood food like? What were your ancestral foods?

Are you currently under medical care?

Who is healthcare provider(s):
Please all providers you are seeing (i.e. naturopaths/md physicians, massage therapists, acupuncturists, other.

Name	**Location**	**Reason for visits?**