Metabolic Intake Form

PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____

Occupation: _____

Who may we thank for referring you to our office?

Friend/Family: _____ Health Care Provider: _____

Online Search: _____ Other: _____

MEDICAL HISTORY

01 Do you or any family member have/had any of the following? Please put an "**X**" for you, and "**F**" for family

- ☐ Depression
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Gallbladder Disease
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Fatigue
- ☐ Brain Fog
- ☐ Hypoglycemia
- ☐ Anemia
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Intestine Problems
- ☐ Shortness of Breath
- ☐ High Cholesterol
- ☐ Headache
- ☐ Poor Sleep
- ☐ Dizziness
- ☐ Arthritis
- ☐ Carpal Tunnel
- ☐ Neuropathy/Nerve Problems
- ☐ Weight Gain
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Knee Pain

☐ **Please check here if you are interested in the practitioner to present a solution for all checked alignments you are experiencing.**

02 Is there a certain time of day any of these problems are better or worse?

_____

_____

03 Are you taking any medications/supplements? If yes, please list.

_____

_____

04 Are you pregnant? _____ How many children? _____ How many Pregnancies? _____
Are you breast feeding? _____

05 Any known allergies? If yes, please list.

_____

_____

06 Main Concerns:

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

07 How long have you had this/these concerns?

_____

_____

08 What effect does this have on your body functions or quality of life?

_____

_____

09 What would be different or better without this/these concerns?

- ☐ Diminished Stress
- ☐ Work
- ☐ More Energy
- ☐ Family
- ☐ Improved Self-Esteem
- ☐ Outlook
- ☐ Confidence
- ☐ Sleep

10 How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other: _____

11 How did the previous methods work for you?

_____

_____

12 What potential barriers do you foresee that would prevent the change you are looking for?

_____

_____

13 Do you feel it possible to eliminate or prevent these potential barriers?

_____

14 What outcome would you like to see for this to be a success for you?

_____

_____

15 Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I AM INTERESTED IN:

☐ Weight Loss ☐ Anti-Aging ☐ Long-Term Results

☐ Inch Loss ☐ Metabolism Support