NATURALLY WITH TAMI:

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Natural Health Practitioner

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NEW CLIENT INTAKE FORM

Personal Information (Information used confidentially)

Name _____ Age _____

Phone (Work/Cell) _____ Email _____

Address _____ City _____

State _____ Zip Code _____ Sex _____ Height _____ Weight _____

Physician (Name/Number) _____

Healthcare History

Please check all conditions that have been diagnosed by a licensed physician within the past three (3) years:

- ☐ Acne
- ☐ Adrenal Imbalance
- ☐ Allergies (Food |Airborne)
- ☐ Anemia
- ☐ Arthritis (Osteo|Rheumatoid)
- ☐ Asthma
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Gastrointestinal Disorder
- ☐ Gynecological Issues
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Insomnia
- ☐ Low Immunity
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Neurological Symptoms
- ☐ Pain (Chronic|Trauma)

☐ **Autoimmune Disease** ☐ **High Blood Pressure** ☐ **Skin Disorders**

☐ **Celiac Disease** ☐ **Hormonal Imbalance** ☐ **Sinus Problems**

☐ **Chronic Fatigue** ☐ **Impaired Liver** ☐ **Thyroid Condition**

☐ **Circulation Issues** ☐ **Infections (Chronic|Viral)** ☐ **Yeast Imbalance**

If you checked YES to any of the conditions above, briefly explain accompanying symptoms:

Do you currently take vitamins or other supplements? ☐ **No** ☐ **Yes** (Please list).

Have you ever been hospitalized for a physical or mental illness? ☐ **No** ☐ **Yes** (Please describe).

Please list any medications that you are currently taking. (Include OTC, non-prescription drugs)

What alternative care have you experienced in the past? (i.e. acupuncture, homeopathy, etc.)

Lifestyle & Diet

Do you exercise? ☐ **No** ☐ **Yes** (Please list how frequently and what kind)

Do you smoke? ☐ **No** ☐ **Yes** (Please list how frequently and starting age)

Emotional Stress Scale (Please circle)

1	2	3	4	5	6	7	8	9	10
No Stress				Moderate				Extreme Stress	

On average, how many hours do you sleep per night?

Please describe your typical dietary choices for breakfast, lunch, and dinner. (i.e. eggs, pasta, salad, etc.)

BREAKFAST:	**Do you consume the following on a regular basis?** (Check all that apply):
LUNCH:	☐ Refined Sugar
SNACKS:	☐ Caffeine
DINNER:	☐ Alcohol
	☐ Gluten
	☐ Wheat
	☐ Dairy
	☐ Processed Foods

Health Concerns

Please list your top four (4) health concerns in order of priority. (Ex. #1. Eczema, #2. Acne, etc.)

#1	#3
#2	#4

Please provide a brief history and/or timeline of your health concerns.

Please describe your long-term health goals and your goal for this appointment today.