

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

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

- I am interested in the practitioner to present solutions for ALL checked ailments I am 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?

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Diminished Stress | <input type="checkbox"/> Family | <input type="checkbox"/> Confidence |
| <input type="checkbox"/> Work | <input type="checkbox"/> Improved Self-Esteem | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> More Energy | <input type="checkbox"/> Outlook | |

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