CLIENT INTAKE FORM

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

At Functional Nutrition Alliance, we are committed to providing compassionate and effective care to all individuals seeking our Functional Nutrition clinical services. Our mission is to empower our clients to achieve their optimal health and we firmly believe that this journey should be accessible to everyone, regardless of their background, identity, or circumstances.

We adhere to the principles of inclusivity, diversity, and respect for all. We do not discriminate on the basis of age, race, ethnicity, physical ability or attributes, body size or weight, religion, sexual orientation, gender identity, or gender expression. We are dedicated to creating a safe, welcoming, and inclusive environment for every individual who walks through our doors.

Our commitment to inclusivity extends to every aspect of our practice including personalized care, cultural sensitivity, accessibility, confidentiality, non-discrimination, input and feedback on improvement. By choosing Functional Nutrition Alliance you are choosing a provider that values your history and identity and is dedicated to helping you achieve your health goals in an inclusive and respectful environment.

We look forward to partnering with you on your journey to optimal health.

Client Information

Name _____

Address _____

City _____ State _____

Country _____ Zip Code _____

Phone (day) _____

Phone (cell) _____

Phone (night) _____

Email _____

Referred by _____

History

Age _____ Birth date _____

Heritage (please specify more information if you'd like)

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Pacific Islander
- ☐ White
- ☐ Latinx
- ☐ Mixed-Race
- ☐ Other
- ☐ Prefer not to answer

Principle language

- ☐ English
- ☐ Spanish
- ☐ Other (please specify)

Birth weight (if known) _____

Birth order (please list ages of biological siblings) _____

_____

Gender at birth _____

Pronouns (she/her, he/him, they/them, other) _____

Gender identity:

- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ Transgender female / woman
- ☐ Transgender male / man
- ☐ Another identity
- ☐ Prefer not to answer

Sexual orientation:

- ☐ Straight
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Asexual
- ☐ Questioning
- ☐ Another orientation
- ☐ Prefer not to answer

Height _____ Blood type (if known) _____

Weight (optional) _____ Weight one year ago (optional) _____

Relationship status (check all that apply):

- ☐ Single
- ☐ Married or living with partner
- ☐ Partnered, not living together
- ☐ Divorced
- ☐ Widowed
- ☐ Other

Partner's pronouns (she/her, he/him, they/them, other) _____

If you have children, please list their age/ages _____

_____

Have you or your family recently experienced any major life changes? If so, please comment:

Occupation _____

_____

Have you lived or traveled outside of the United States? If so, when and where?: _____

_____

_____

_____

Medical Status

1. Please identify any current or past conditions and add a date for when the condition appeared. In the space below each list, please briefly describe your symptoms, chosen treatment(s), and dates.

Gastrointestinal

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Irritable Bowel Syndrome	☐	☐	_____	Gut infections
☐	☐	_____	Crohn's	☐	☐	_____	Dysbiosis
☐	☐	_____	Ulcertative Colitis	☐	☐	_____	Leaky gut
☐	☐	_____	Gastritis or Peptic Ulcer Disease	☐	☐	_____	Food allergies, intolerances or reactions
☐	☐	_____	GERD (reflux or heartburn)	☐	☐	_____	Gallstones
☐	☐	_____	Celiac Disease	☐	☐	_____	Known absorption or assimilation issues
☐	☐	_____	SIBO	☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Cardiovascular

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Heart attack	☐	☐	_____	Hypertension (high blood pressure)
☐	☐	_____	Heart Disease	☐	☐	_____	Rheumatic Fever
☐	☐	_____	Stroke	☐	☐	_____	Mitral Valve Prolapse
☐	☐	_____	Elevated cholesterol	☐	☐	_____	Other
☐	☐	_____	Arrhythmia (irregular heartbeat)				

Please briefly describe your symptoms, chosen treatment(s) and dates:

Hormones/Metabolic

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Type 1 Diabetes	☐	☐	_____	Endocrine problems
☐	☐	_____	Type 2 Diabetes	☐	☐	_____	Polycystic Ovarian Syndrome (PCOS)
☐	☐	_____	Hypoglycemia	☐	☐	_____	Infertility
☐	☐	_____	Metabolic Syndrome	☐	☐	_____	Weight gain
☐	☐	_____	Insulin Resistance or Pre-Diabetes	☐	☐	_____	Weight loss
☐	☐	_____	Hypothyroidism (low thyroid)	☐	☐	_____	Frequent weight fluctuations
☐	☐	_____	Hyperthyroidism (overactive thyroid)	☐	☐	_____	Eating disorder
☐	☐	_____	Hashimoto's (autoimmune hypothyroid)	☐	☐	_____	Menopause difficulties
☐	☐	_____	Grave's Disease (autoimmune hyperthyroid)	☐	☐	_____	Hair loss
				☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Cancer

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Lung Cancer	☐	☐	_____	Prostate Cancer
☐	☐	_____	Breast Cancer	☐	☐	_____	Skin Cancer (Melanoma)
☐	☐	_____	Colon Cancer	☐	☐	_____	Skin Cancer (Squamous, Basal)
☐	☐	_____	Ovarian Cancer	☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Genital & Urinary Systems

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Kidney Stones	☐	☐	_____	Gout

- [ ] [ ] _____ Frequent urinary tract infections
- [ ] [ ] _____ Erectile Dysfunction or Sexual Dysfunction
- [ ] [ ] _____ Interstitial Cystitis
- [ ] [ ] _____ Frequent Yeast Infections
- [ ] [ ] _____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Musculoskeletal/Pain

PAST NOW DATE

- [ ] [ ] _____ Osteoarthritis
- [ ] [ ] _____ Fibromyalgia
- [ ] [ ] _____ Chronic Pain
- [ ] [ ] _____ Sore muscles or joints, undiagnosed
- [ ] [ ] _____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Immune/Inflammatory

PAST NOW DATE

- [ ] [ ] _____ Chronic Fatigue Syndrome
- [ ] [ ] _____ Rheumatoid Arthritis
- [ ] [ ] _____ Lupus SLE
- [ ] [ ] _____ Raynaud's
- [ ] [ ] _____ Psoriasis
- [ ] [ ] _____ Mixed Connetive Tissue Disease (MCTD)
- [ ] [ ] _____ Poor immune function (frequent infections)
- [ ] [ ] _____ Food allergies
- [ ] [ ] _____ Environmental allergies
- [ ] [ ] _____ Multiple chemical sensitivities
- [ ] [ ] _____ Latex allergy
- [ ] [ ] _____ Hepatitis
- [ ] [ ] _____ Lyme (and co-infections)
- [ ] [ ] _____ Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, HPV, STIs, etc.)
- [ ] [ ] _____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Respiratory Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Asthma	☐	☐	_____	Sleep Apnea
☐	☐	_____	Chronic Sinusitis	☐	☐	_____	Frequent or recurrent Colds/Flus
☐	☐	_____	Bronchitis				
☐	☐	_____	Emphysema	☐	☐	_____	Other
☐	☐	_____	Pneumonia				

Please briefly describe your symptoms, chosen treatment(s) and dates:

Skin Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Eczema	☐	☐	_____	Acne
☐	☐	_____	Psoriasis	☐	☐	_____	Skin Cancer (Melanoma)
☐	☐	_____	Dermatitis	☐	☐	_____	Skin Cancer (Squamous, Basal)
☐	☐	_____	Hives				
☐	☐	_____	Rash, undiagnosed	☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Neurologic/Mood

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Depression	☐	☐	_____	Autism
☐	☐	_____	Anxiety	☐	☐	_____	Mild Cognitive Impairment
☐	☐	_____	Bipolar Disorder	☐	☐	_____	Memory problems
☐	☐	_____	Schizophrenia	☐	☐	_____	Parkinson's Disease
☐	☐	_____	Headaches	☐	☐	_____	Multiple Sclerosis
☐	☐	_____	Migraines	☐	☐	_____	ALS
☐	☐	_____	ADD/ADHD	☐	☐	_____	Seizures

☐ ☐ _____ Concussion/Traumatic Brain Injury

☐ ☐ _____ Alzheimer's

☐ ☐ _____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Miscellaneous

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Anemia	☐	☐	_____	Mumps
☐	☐	_____	Chicken Pox	☐	☐	_____	Whooping Cough
☐	☐	_____	German Measles	☐	☐	_____	Tuberculosis
☐	☐	_____	Measles	☐	☐	_____	Known genetic variants (SNPs, polymorphisms, etc)
☐	☐	_____	Mononucleosis	☐	☐	_____	Other

2. Please check frequency of the following:

Short term memory impairment	☐ yes	☐ no	☐ sometimes
Shortened focus of attention and ability to concentrate	☐ yes	☐ no	☐ sometimes
Coordination and balance problems	☐ yes	☐ no	☐ sometimes
Problems with lack of inhibition	☐ yes	☐ no	☐ sometimes
Poor organization abilities	☐ yes	☐ no	☐ sometimes
Problems with time management (late or forget appts)	☐ yes	☐ no	☐ sometimes
Mood instability	☐ yes	☐ no	☐ sometimes
Difficulty understanding speech and word finding	☐ yes	☐ no	☐ sometimes
Brain fog, brain fatigue	☐ yes	☐ no	☐ sometimes
Lower effectiveness at work, home or school	☐ yes	☐ no	☐ sometimes
Judgment problems like leaving the stove on, etc	☐ yes	☐ no	☐ sometimes

Stressful Life Events

Studies show that past and continued traumas play a significant role in health and health outcomes. Our understanding of your history helps us to best support you throughout this process and moving forward.

3. Have you experienced one or more of these stressful life events or traumas in your life?

Death of a family member, romantic partner or very close friend because of accident, homicide, or suicide	☐ yes	☐ no
Sexual or physical abuse by a family member, romantic partner, stranger, or someone else	☐ yes	☐ no
Emotional neglect or abuse such as ridicule, bullying, put downs, being ignored or told you were no good by a family member or romantic partner	☐ yes	☐ no
Discrimination	☐ yes	☐ no
Life-threatening accident or situation (military combat or lived in a war zone)	☐ yes	☐ no
Life-threatening illness	☐ yes	☐ no
Physical force or weapon threatened or used against you in a robbery or mugging	☐ yes	☐ no
Witness the murder, serious injury or assault of another person	☐ yes	☐ no

4. Is there anything else that you'd like to share about these stressful life events or traumas?

Health Concerns

5. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

6. When did you first experience these concerns?

7. How have you dealt with these concerns in the past?

   ☐ doctors ☐ self-care

8. Have you experienced any success with these approaches? Please explain.

9. What other health practitioners are you currently seeing? List name, specialty below.

10. Please list the date and description of any surgical procedures you have had (including breast reduction or augmentation, gall bladder removal, and any office procedures).

11. How much time have you had to take off from work or school for health related reasons in the last year? (add details if you can)

12. How often did you take antibiotics in infancy/childhood?

13. How often have you taken antibiotics as a teen?

14. How often have you taken antibiotics as an adult?

15. List any medicine you are currently taking:

16. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

Nutritional Status

17. Which of the following foods do you consume regularly?

- ☐ soda
- ☐ diet soda
- ☐ refined sugar
- ☐ alcohol
- ☐ gluten (wheat, rye, barley)
- ☐ fast food
- ☐ dairy (milk, cheese, yogurt)
- ☐ coffee

18. Are you currently on a special diet?

- ☐ autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free
- ☐ ketogenic diet
- ☐ intermittent fasting
- ☐ Other (please describe)

19. What percentage of your meals are home-cooked?

☐ 10	☐ 30	☐ 50	☐ 70	☐ 90
☐ 20	☐ 40	☐ 60	☐ 80	☐ 100

20. Are there any foods that you avoid because of the way they make you feel?
If yes, please name the food and the symptom:

21. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives?
Do you have any known food allergies or sensitivities? If so, please explain:

22. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

23. Are there foods that you crave? If so, please explain:

24. Describe your diet at the onset of your health concerns:

25. Do you have any known food allergies or sensitivities?

26. Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

27. Bowel movement frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

28. Bowel movement consistency

- ☐ soft & well formed
- ☐ often float
- ☐ difficult to pass
- ☐ diarrhea
- ☐ thin, long or narrow
- ☐ small and hard
- ☐ loose but not watery
- ☐ alternating between hard and loose

29. Bowel movement color

- ☐ medium brown
- ☐ very dark or black
- ☐ greenish
- ☐ blood is visible
- ☐ variable
- ☐ yellow, light brown
- ☐ chalky colored
- ☐ greasy, shiny

30. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

31. Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

Potential Health Hazards

32. To your knowledge, have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

33. Do odors affect you?

34. Are you or have you been exposed to second-hand smoke?

35. Are you currently or have you been exposed to mold? (If so, what is/was the source of the exposure and for how long have you been/were you exposed to mold, if known?)

36. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

Oral Health History

37. How long since you last visited the dentist? What was the reason for that visit?

38. In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

39. What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

40. Do you have any mercury amalgams? (If no, were they removed? If so, how?)

41. Have you had any root canals? (If yes, how many and when?)

42. Do you have any concerns about your oral or dental health? (gums bleed after flossing, receding gums)

43. Is there anything else about your current oral or dental health or health history that you'd like us to know?

Sleep History

44. Are you satisfied with your sleep?

45. Do you stay awake all day without dozing?

46. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

47. Do you fall asleep in less than 30 minutes?

48. Do you sleep between 6 and 8 hours per night?

49. Is there anything else you would like us to know about your sleep?

Reproductive Hormone History

If you do not have female reproductive organs please skip to question 57.

50. How old were you when you first got your period?

51. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

52. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

53. Have you experienced any yeast infections or urinary tract infections? Are they regular?

54. Have you/do you still take birth control pills: If so, please list length of time and type.

55. Have you had any problems with conception or pregnancy?

56. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Mental Health Status

57. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

58. On a scale of 1–10, one being the worst and 10 being the best, describe your usual level of energy.

59. At what point in your life did you feel best? Why?

Other

60. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

61. Who in your family or on your health care team will be most supportive of you making dietary change?

62. What role does spirituality play in your life?

63. Please describe any other information you think would be useful in helping to address your health concern(s):