

920-933-7158

Dear Client, Please complete this form as fully as possible. If there are areas you are unsure about, we can discuss them during our initial consultation. The information you share here is private and confidential, and held with the utmost respect. These details will help me to understand you and your needs and ultimately achieve the best results. Thank you for your time.

**Intake Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone # to contact you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_ 1 year ago:\_\_\_\_\_\_\_\_\_\_ 5 years ago:\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**** Full Time ****Part Time

What are your major health concerns and intentions for contacting me?

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Please list any other health care providers or consultants you are currently working with:

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Please list any current health conditions diagnosed by a medical doctor:

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When was your last physical exam?

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Please list all herbs, vitamins, and dietary supplements you are currently taking, including dosage and frequency:

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List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or Prescription, including dosage and frequency:

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List all medications, herbs, foods, environmental factors, to which you have a known allergy:

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Please list any cravings you may have, and time of day these occur, example sugar or sweet foods after main meals, salt or bread or cookies mid-afternoon:

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Please list whether you use these products or have in the past:

Aluminum pots, cookware, foil, deodorants and toothpaste containing aluminum \* Yes \* No

Have or had mercury fillings in your teeth \* Yes \* No

Have or do use a lot of soy foods or soy-based foods, milks \* Yes \* No

Have or had older carpets, wall to wall carpets \* Yes \* No

Used pesticides, weed killers or harsh chemicals \* Yes \* No

Prepare food in a microwave oven \* Yes \* No

Wear synthetic materials \* Yes \* No

Experience sensitivity to perfumes or other chemical odors \* Yes \* No

**DIETARY INFORMATION**

Describe below your typical meals. Please be as specific as possible. For example, instead of “oil” note type of oil, such as olive, corn, etc. Instead of “bread” list whether white or whole grain, etc. Instead of “vegetables” list the type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include all beverages, type and quantity (two cups of orange juice, one cup of coffee, etc.,).

Breakfast:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Morning snack(s):

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Lunch:

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Afternoon snack(s):

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Dinner:

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Daily filtered or spring water consumption (number of glasses/day): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.) please list as many as applicable including time of day or month:

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**FAMILY HISTORY**

Please describe any relevant or major health related issues: (cancer, mental

illness, diabetes, heart disease, etc.)

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandmother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandfather: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandmother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandfather: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

List all major health problems including any operations:

**PROBLEM YEAR**

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**GENERAL HEALTH**

**Cardiovascular Skin Muscles/Joints**

**** High blood pressure **** Boils **** Backache

**** Low blood pressure **** Bruises **** Broken bones

**** Pain in heart **** Dryness **** Limited mobility

**** Poor circulation **** Itching **** Arthritis

**** Swelling **** Varicose veins **** Bursitis

**** Stroke/murmur **** Skin eruptions **** Weakness

**Respiratory Urinary/Kidney Gastro-Intestinal**

**** Chest pain **** Excessive urination **** Belching

**** Difficulty breathing **** Water retention **** Colitis

**** Cough **** Burning urine **** Constipation

**** Tuberculosis **** Kidney stones **** Abdominal pain

**** Congestion **** Lower back pain **** Liver disorders

**** Itchy ears/eyes **** Wheezing **** Gallstones

**** Asthma **** Circles under eyes **** Ulcers

**** Coughing up blood **** Blood in urine **** Digestive troubles

**Eyes, Ears, Nose and Throat**

**** Ear aches **** Eye pains **** Failing vision

**** Hay fever **** Sinus infections **** Sinus congestion

**** Sore throat **** Tonsils **** Hearing loss

**** Canker sores **** Nosebleeds **** Difficulty breathing

**General**

**** Fatigue **** Night sweats **** Fever

**** Excessive thirst **** Loss of appetite ****Always hungry

**** Difficulty sleeping **** Irritability **** Cold hands and feet ****Constipation ****Diarrhea

**Male Reproductive**

**** Burning/discharge **** Lumps/swelling of testicles

**** Painful testicles **** Vasectomy

**Female Reproductive**

Age of first period: \_\_\_ **** Irregular cycles **** Pre-menopausal

**** Heavy bleeding **** Blood clots **** Menopause

**** Vaginal discharge **** Vaginal itching **** Pains/cramps

**** Painful intercourse **** Vaginal dryness **** Pelvic pain

**** Breast pain **** Breast lumps **** Anemia

**** Infertility **** Genital herpes **** Hot flashes

**** Mood Swings **** PMS **** Not able to conceive

**Contraceptive/Pregnancy History**

**** Oral contraceptives **** Rhythm-method **** I.U.D.

**** Diaphragm **** Condoms **** Mucous-method

**** Cervical Cap **** Spermicides **** Fertility lens

Please list each pregnancy you have had, including miscarriages:

**CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING**

*Please click all those that describe you:*

**** I am often not able to express my emotions.

**** I am dissatisfied with my job.

**** I am often stressed out and not able to cope properly.

**** Even though I’m in a relationship, I often feel lonely.

**** I often feel anxious and nervous for no good reason.

**** I don’t sleep well at night and have a hard time waking up in the morning.

**** I often suffer from bad dreams and nightmares.

**** There are many things I’d like to change in my life I just don’t have the means.

**** I have very low energy and often feel exhausted mentally and physically.

**** I don’t enjoy my work and would rather be doing something else.

**** I find my children irritating and hard to relate to.

**** I have very few hobbies.

**** I often feel depressed for no reason.

**** I often become angry with people and feel guilty about it later.

**** I have a hard time letting go of the past.

**** I don’t look towards the future with much enthusiasm.

**** I am not able to concentrate for extended periods of time.

**** My outlook is more negative than positive.

**** I spend a great deal of time worrying about what people think about me.

**** I tend to see the good in people.

**** I have a great sense of humor and love a good joke.

**** I receive great joy from my family.

**** My outlook on life is positive.

**** My job uses all my greatest talent.

**** I have plenty of energy to do all the things I want.

**** I sleep well at night and feel rested in the morning.

**** I can concentrate on the task at hand for as long as it takes.

**** I have a strong spiritual faith.

**** I am able to express anger constructively.

**** I practice meditation or other relaxation techniques.

**** I try to maintain peace of mind and tranquility.

**** I have many close friends that I can always count on.

**** I accept full responsibility for my actions.

**** I trust my intuition and believe that things happen for a reason.

**** I do not harbor any resentment from the past.

**** I can feel completely fulfilled even if I’m alone.

**** I have many hobbies and interests to keep me preoccupied.

**** How I see myself is more important than how others see me.

**** I often go out of my way to help others.

Please list approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, surgery, end of a relationship, loss of job, change of residence, injury, death of a loved one, etc.)

**YEAR/ EVENT**

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**LIFESTYLE HABITS**

Do you engage in regular physical activity? **** Yes **** No

If yes, for how many minutes? \_\_\_\_\_\_\_\_\_\_\_\_\_How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke tobacco or are you in a situation or have you been in one, where you are subjected to secondhand smoke? **** Yes **** No

If yes, how much? \_\_\_\_\_\_\_\_/day

Do you drink alcohol? **** Yes **** No

If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink coffee and/or caffeinated beverages? **** Yes **** No

If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use artificial sweeteners? **** Yes **** No

Have you suffered from depression in the past? \* Yes \* No

Please use this space to add any other information about yourself that you think will be

helpful,( please use a separate sheet if you have more information than can fit in this space):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please bring this form with you to your appointment.

Blessings and true health to you,

Shannon Ashcroft

Licensed Ecclesiastical Holistic Practitioner, Naturopathic Doctor Candidate, Health Kinesiologist, Iridologist

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