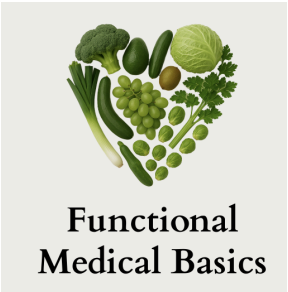

INTAKE FORM

Have you ever been a patient with us before? ☐ Yes ☐ No

Name: _____DOB:_____
Address: _____
Email address: _____ Phone #: _____.

History and Habits:

Reason you are here**:**

Medical History:

Family History:

Medication:

3 Day Diet- Meals and snacks
Day 1

Day 2

Day 3

What do you drink:

Food allergy or sensitivity:

Exercise- movement record this week:

Walking/running/biking_____ Strength/weights_____

Yoga/stretching_____ Sports _____

Sleep:

How many hours/night_____ Frequent wakening_____ Snoring_____

Sleep aids_____Sleep apnea symptoms_____

Alcohol:

Drinks/week_____Previous alcohol intake_____

Have you ever been told to cut down on your alcohol intake_____

Smoking:

Current_____ Past_____

Attempts to quit_____

Recreational Drugs:

Trauma/stress:

Toxins:

Mold Exposure:

Lyme/Infections:
