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Intake Form

I appreciate your patience in completing this intake form. This is essential to your accurate assessment and our work together. The more I know about you and your health, the better equipped I am to create a personalized plan for you. This form can be completed electronically – please save this file as your full name and email to dora@dorachanyoga.net Thank you.

Date: _____

Referred by: _____

Title: _____ **Last Name:** _____

First Name: _____ **Middle Name:** _____

Address: _____

_____

Home phone number: _____

Work phone number: _____

Mobile number: _____

Email address: _____

Occupation: _____

Date of Birth: _____ **Age:** _____

Sex: _____ **Height:** _____ **Current Weight:** _____

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What are your main health and/or personal concerns that you would like to address in working with me?

When did you first experience these concerns (health/personal)? Did anything trigger or precede your concern(s)?

Describe your diet when the concern(s) started.

How have you addressed the concern(s), currently and in the past? (i.e. doctor, self-care, nutrition, acupuncture, etc.)

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How was your experience with these treatments/practices? Did they have a positive or negative effect impact?

What do you hope to learn and achieve from working with me?

PERSONAL HEALTH HISTORY

What practitioners are you currently seeing? May I contact them with your permission? If yes, please list your practitioners' name, specialty, and contact details (phone/email).

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Have you experienced any major traumas in the last 5 years?

_____

_____

On a scale of 1 (lowest) to 10 (highest), what level of stress are you feeling at this time?

_____

How does your stress manifest itself?

What are the major causes or factors of your stress? Rate all that apply on a scale of 1 (lowest) to 10 (highest):

☐ Financial _____ ☐ Personal _____ ☐ Other (please elaborate) _____

☐ Career _____ ☐ Health _____ _____

☐ Family _____ ☐ Spiritual _____ _____

☐ Marriage _____ ☐ Unfulfilled expectations _____

Do you use any coping mechanisms?

_____

_____

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Were you born:

☐ Vaginally ☐ C-Section ☐ Complications during labour? _____

Were you breastfed or bottle-fed as a baby? _____

If breastfed, for how long? _____

If bottle fed, when was formula introduced? _____

Describe your health history as a child (i.e. healthy, frequently sick, ear infections, emotional trauma, etc.).

Describe how frequently you have taken antibiotics over the course of your life (as a child, as a teenager, and as an adult), include long-term use for acne and short-term courses.

Have you had any major life changes or losses (especially in the recent past or coinciding with the onset of your concern)?

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List your current list of medications, include condition (i.e. Zoloft for depression).

List your current supplements, include form, dosage, and frequency (i.e. Calcium citrate, 400mg twice/day).

Have you ever been diagnosed with an illness? If so, please explain.

Have you ever been hospitalized? If so, what was the reason?

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DIET

Are you on any of the following special diets?

- ☐ GFCF
- ☐ SCD/GAPS
- ☐ Paleo
- ☐ Autoimmune Paleo
- ☐ Feingold/Failsafe
- ☐ Body Ecology Diet
- ☐ Low Oxalate
- ☐ Low FODMAP
- ☐ Low Histamine
- ☐ Low Carbohydrate
- ☐ Ketogenic Diet
- ☐ Vegetarian
- ☐ Vegan
- ☐ No Special Diet

Which of the following foods do you have allergies or food sensitivities? If so, do you currently avoid them? Please mark the following:

	Serious Allergy	Sensitivity	Avoiding	Comments/Additional Information
Gluten	☐	☐	☐	
Dairy/Casein	☐	☐	☐	
Soy	☐	☐	☐	
Corn	☐	☐	☐	
Eggs	☐	☐	☐	

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Sugar	☐	☐	☐	
Chocolate	☐	☐	☐	
Peanuts	☐	☐	☐	
Citrus	☐	☐	☐	

Any other foods? _____

_____

_____

How were the food sensitivities determined? What type of allergy testing identified these allergens/sensitivities (i.e. skin/scratch, IgE/IgG, muscle testing, dietary elimination, known reaction, other)?

_____

_____

_____

If you are not currently gluten-free, do you suspect that you are:

☐ Gluten Sensitive ☐ Casein Sensitive Explain: _____

_____

Have you ever tried eliminating gluten and dairy, and did you notice any effects?

_____

_____

Have you had surgery to remove your:

☐ Gallbladder ☐ Tonsils ☐ Appendix

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What are you favourite foods? _____

How often do you eat them? _____

Do you have any significant food cravings? _____

How often do you eat them? _____

Do you have any other dietary restrictions?

_____

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks: _____ Times of day: _____

Describe your diet now

Do you eat meals:

☐ With family ☐ Home alone ☐ On the run

☐ In restaurants ☐ Fast food

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Do you feel there are restrictions to your diet due to preferences of others such as family, roommates, etc.? If yes, please explain.

_____

_____

_____

Do you eat fish? How often and what type?

_____

Do you eat sauerkraut? How often and what type?

_____

Do you consume bone broth? How often and what type?

_____

How much water do you drink per day? What type (tap, bottled, filtered)?

_____

How much wine, beer, or alcohol do you consume per week?

_____

Do you experience any symptoms after meals? Please explain. _____

_____

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Do you consume or use the following: (Indicate "1" for "rarely", "2" for "regularly", "3" for "often")

- ☐ Coffee _____
- ☐ Caffeine _____
- ☐ Soda _____
- ☐ Diet Soda _____
- ☐ Sweetened Drinks _____
- ☐ Artificial Sweeteners _____
- ☐ Trans Fats _____
- ☐ Margarine _____
- ☐ MSG _____
- ☐ Candy _____
- ☐ Cigarettes _____
- ☐ Aluminium pans _____
- ☐ Canned soups _____
- ☐ Canned/boxed broths _____
- ☐ Non-organic Gluten-free packaged foods _____
- ☐ Non-organic meat, eggs, or dairy _____
- ☐ Non-organic fruits and vegetables _____
- ☐ Non-organic corn, soy, canola, "sugar" (beet) _____
- ☐ Non-organic papaya, summer squash _____
- ☐ Fried foods _____
- ☐ Luncheon meats _____
- ☐ Fast foods _____
- ☐ Refined foods (pastries, white bread/pasta etc.) _____
- ☐ Microwave _____

Please indicate how many cups of the following you drink per day:

Drink	**Cups/day**	**Drink**	**Cups/day**
Tap Water		Fresh vegetable juices	
Bottled or spring water		Prepared vegetable juices	
Filtered water		Red wine	
Coffee		White wine	
Soda (diet)		Beer	
Soda (regular)		Other alcoholic beverages	
Fresh fruit juices		Tea	
Prepared fruit juices		Herbal Tea	
Milk (1%, 2%, or whole)		Other	
Milk (skim)			

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Do you have exposure to the following:

- ☐ Fluoridated water
- ☐ Chlorinated pools
- ☐ Chemical cleaning supplies
- ☐ Perfume/fragrance
- ☐ Fabric softener/drier sheets
- ☐ Tobacco

Do you consume large amounts of AND/OR have cravings for any of the following?

- ☐ Berries
- ☐ Apple juice
- ☐ Grapes/raisins
- ☐ Bananas
- ☐ Honey
- ☐ Curry powder
- ☐ Spices/culinary herbs
- ☐ Medicinal herbs
- ☐ Wine
- ☐ Bone broth
- ☐ Sauerkraut
- ☐ Fermentations
- ☐ Soy sauce
- ☐ Vegemite/Marmite
- ☐ Parmesan cheese
- ☐ Tomato sauce
- ☐ Artificial colours
- ☐ Artificial flavours
- ☐ Preservatives
- ☐ Sulfites
- ☐ Fragrance/perfume
- ☐ Aspirin
- ☐ Tylenol (acetaminophen)

Do you have reactions to any foods? If yes, please list the foods and reactions.

_____

_____

Do you consume any of the following foods 3 x per week or more?

- ☐ Spinach
- ☐ Swiss chard
- ☐ Nuts
- ☐ Almond/almond flour
- ☐ Beans
- ☐ Soy
- ☐ Chocolate
- ☐ Black tea
- ☐ Blackberries
- ☐ Figs
- ☐ Kiwi
- ☐ Beets
- ☐ Buckwheat
- ☐ Chia seeds
- ☐ Amaranth
- ☐ Tahini

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ENERGY/MOODS/SLEEP

On a scale of 1 (lowest) to 10 (highest), how would you describe your energy levels?

_____

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day?

_____

_____

Have you been diagnosed or believe you may have hypoglycemia? _____

Do you need to eat frequently? _____

Do you get irritable, dizzy, headaches when you go too long without eating? _____

Do you experience any symptoms if meals are missed? Please explain.

_____

_____

Do you suffer from fatigue, depression, or anxiety? If so, please explain

_____

_____

How many hours do you work each day? _____

At what times do you start and end work? _____

Do you enjoy your work? _____

On average, how much sleep do you get per night? _____

Do you do shift work or are you on a regular schedule? _____

Do you have trouble falling asleep? _____

What time do you go to bed and awaken? _____

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Do you wake in the night? If so, what time and for what reason? (i.e. kids, work, mental chatter)

_____

How long does it take to fall back asleep? _____

Do you feel refreshed after a full night's sleep? _____

BODY/EXERCISE

Have you experienced any recent weight changes (gain or loss)? _____

Do you have a history of extreme dieting or eating disorders (i.e. yo-yo dieting, calorie restriction, etc.)?

_____

Do you want to change your weight? If so, how? _____

What is your main motivation to change your weight? _____

By when do you wish to reach your weight goal? _____

What do you do for exercise? Please elaborate on the following:

Type of exercise/activity	Duration	Frequency

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Do you feel energized or depleted after exercise? _____

On average, how many hours do you spend daily doing the following:

Driving _____ Watching TV _____ Reading _____ In front of computer _____

Do you vacation regularly? _____

When was your last vacation? _____

What are your interests or hobbies? _____

_____

Do you actively participate in any spiritual discipline (i.e. church, religious groups, meditation)? If so, please explain.

_____

_____

WOMEN'S HEALTH

Do you still have menstrual periods? _____

On average, what are the number of days between cycles? _____

What is the length of the menstruation? _____

Have you noticed any changes in menses (i.e. frequency, flow, clotting, duration, etc)?

_____

Are you currently pregnant? _____ If so, how may weeks? _____

Are you trying to get pregnant? _____ Are you nursing? _____

What is the number of children you have? _____

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What are the genders of your children? _____

What are the ages of your children? _____

Do you have PMS, cramps, estrogen dominance, Polycystic Ovarian Syndrome (PCOS), or other symptoms?

_____

Do you take hormones (i.e. birth control pills or hormone replacement)?

_____

Are you peri-menopausal? _____ Are you menopausal? _____

Are you experiencing any menopausal symptoms? If yes, please specify. _____

_____

Have you had a bone density test? If yes, what was the result? _____

_____

MEN'S HEALTH

Have you experienced any prostate problems (i.e. frequent urination, discomfort during urination)? If yes, please describe:

_____

_____

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DIGESTION AND ELIMINATION

How frequently do you have a bowel movement?

_____

What is the consistency of the stool? Refer to the Bristol Stool Chart.

_____

Do you strain to have a bowel movement?

☐ Yes ☐ No ☐ Occasionally

Do you have frequent gas? _____

Do you have bloating? _____

Does gas have a strong odour? _____

Do you have diarrhea or soft, unformed stool?

☐ Yes ☐ No ☐ Occasionally

Do you tend to have constipation?

☐ Yes ☐ No ☐ Occasionally

Do you have burping, heartburn, or acid reflux? Do you take antacids or acid blockers?

_____

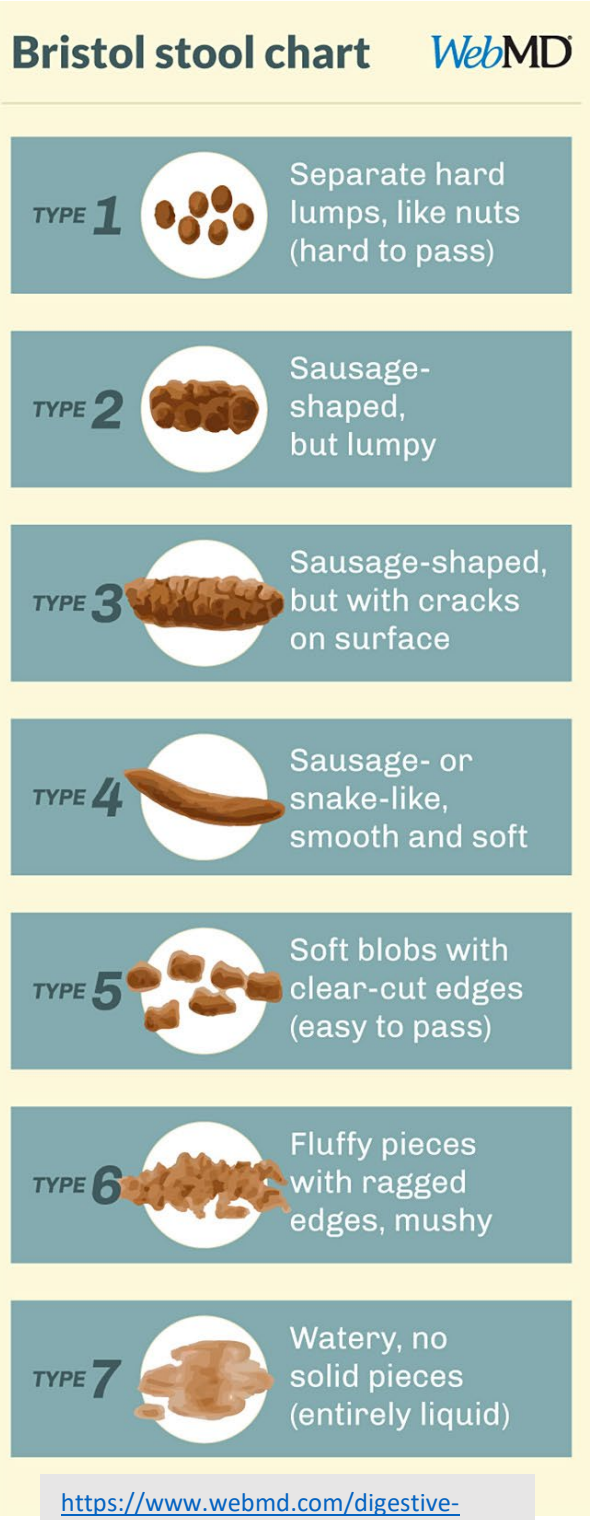
_____

Describe any other digestive issues?

_____

_____

_____



https://www.webmd.com/digestive-disorders/poop-chart-bristol-stool-scale

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TOXIC EXPOSURE

Do you smoke? _____ If yes, how much and for how long?

_____

If no, does anyone in your household or workplace smoke? _____

Do you have/have you ever had any silver-mercury fillings? If so, for how long?

_____

Have you had exposure to any toxins (pesticides, chemicals, heavy metals, plastics, inhaled chemicals, industrial chemicals) that you are aware of at your home or office?

_____

_____

Have you received any vaccinations including the flu shot? _____

When was your last vaccination? And what was it for?

_____

Are there any chemicals or smells that you are sensitive to (headaches, nausea)?

_____

Have you recently remodelled or plan to remodel your home? What did you have done?

_____

Do you have any of the following?

☐ Lyme disease and co-infections

☐ Candida overgrowth (yeast infections, nail fungus, athlete's foot)

☐ Viral infections (EBV, HVS, and others)

☐ Clostridia and other gut pathogens

☐ SIBO

☐ Mold exposure and mycotoxins

☐ Exposure to water damaged buildings

☐ Glyphosate exposure

☐ Heavy metal toxicity

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FAMILY HISTORY

Please indicate any family history of the following and list family member affected, mark paternal or maternal with a "p" or "m", respectively, or SELF. For example: p-grandmother, m-aunt, etc.

Diabetes/Hypoglycemia _____ Colitis/IBS/IBD _____

Heart Disease _____ Hypertension _____

Cancer _____ Autoimmune disorder _____

Obesity _____ Migraines/Headaches _____

Depression, anxiety _____ Postpartum depression _____

ADHD, Autism _____ Bipolar, schizophrenia _____

Asperger's _____ Recurring yeast (vagina, foot, etc) _____

Hyperactivity, tics _____ Vulvadynia _____

Kidney stones _____ Kidney dysfunction _____

Alzheimer's _____ Multiple chemical sensitivity _____

Alcohol/chemical dependency _____ Fibromyalgia _____

Epilepsy/seizures _____ Chronic fatigue syndrome _____

Rheumatoid arthritis _____ Arthritis _____

Hashimoto's thyroiditis _____ Hypothyroid _____

Grave's Disease _____ Allergies _____

Gallbladder issues _____ Sleep apnea_____

Asthma _____ Skin conditions _____

Osteoporosis_____ Liver issues _____

Lyme Disease_____

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Have you experienced a decline in sexual interest? ☐ Yes ☐ No

If yes, please describe:

_____

Have you had kidney or gall stone? ☐ Yes ☐ No

If yes, please describe: _____

Any other comments? _____

_____

_____

_____

Thank you for taking the time to complete this intake form. Please also remember to complete the *Nutri-body Questionnaire* and your *2-Day Food & Lifestyle Journal.* Please send all your completed forms to dora@dorachanyoga.net

Note: Your Nutri-body Questionnaire will be submitted online automatically.

I look forward to working with you!