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New Client Intake Form

Name: _____ Date of Birth: _____

Address: _____

Phone # (s) _____

Email: _____

Height: _____ Present Weight: _____ Your Ideal Weight: _____

How did you hear about our services? _____

List your main concerns or symptoms in your way to being your optimal self.

(How long have these been issues?)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

List your main goals to get you to the ideal person you want to become.

(How committed to change are you?)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Symptoms and Overall Health

Other health practitioners/doctors you are seeing/have seen recently and why _____

Please list any drugs (prescription, over-the-counter, recreational) you are taking/have recently _____

Please list any supplements (vitamins, minerals, herbs, homeopathics) you are taking _____

Major surgeries? Missing any organs? (gall bladder, tonsils, appendix, wisdom teeth?) _____

What major health issues run in your family? _____

Finish this sentence - "I haven't felt the same since....." _____

Please check any issues below that apply to you

Constipation (fewer than 1 bowel movement a day)	
Diarrhea	
Acid reflux, indigestion, heartburn (circle)	
Excessive gas, belching or burping	
Stomach cramping, irritable or spastic bowel	
Hemorrhoids	
Urgent or frequent urination	
Experience hunger almost constantly	
Feel unwell if don't eat regularly, miss a meal	
Feel better when don't eat	
Craving for salt	
Craving for sweets or starches	
Craving for chocolate	
Crave or consume daily tobacco/alcohol/caffeine	
Cardiovascular health / blood pressure issues	
Heart palpitations or irregular heartbeat	
Headaches, migraines	
Back pains, neck pains	
Arthritis, joint pains	
Anemia, low iron	

Lightheadedness or dizziness	
Nausea	
Dry / leathery skin, dry hair	
Skin bruises easily	
Wounds heal poorly, slowly	
Thyroid issues	
Low body temperature	
Cold hands or feet	
Gain weight easily, sluggish metabolism	
Lose weight easily, fail to gain weight	
Hyperactivity	
Dry / inflamed eyes, discharge	
Eyes sensitive to light	
ringing in ears	
Frequent colds, sniffles	
Frequent infections: virus / bacterial / ear / sinus / other	
Yeast infections	
P.M.S., menstrual cramping, clotting	
Decline in sexual interest, feelings, ability	
Mood swings	

Anxiety, easily startled	
Irritability	
Depression	
Perfectionist	
Uneasy as centre of attention	
Tightness in throat when emotional	
Low self confidence	
Easily distracted, difficulty concentrating	
Periods of "foggy" or "fuzzy" thinking; staring or "stunned" feeling	
Bothered by chemical or perfume odours	
Food or Environmental Allergies	
Diabetes / Hypoglycemia	
Disordered Eating	
Physical /Repetitive Injury	
Asthma / Bronchitis	
Acne / Eczema / Psoriasis / Hives /Rashes	
Cancer	
Insomnia / Frequent Waking	
Liver / Gallbladder problems	

Please elaborate on the above, and add any other diagnoses, labels, or health issues that you have currently or had in the past.

Describe a typical day/week's bowel pattern (frequency, constipation/diarrhea, hard/soft, easy/painful). Are there specific foods that effect your digestion?

Teeth – do you have silver amalgams? Any amalgams or teeth removed? Root canals?

Have you ever been on antibiotics or a birth control pill? When? How long?

Were you breastfed? Canal or caesarian birth?

Did you receive childhood vaccines? Flu shot? H1N1 vaccine? Hep B? etc.

Describe your energy levels. Do you get tired, fatigued, or lack energy over the day?

Sleep – how many hours/night? Do you wake feeling rested?

Rate your stress level (1-10). Main sources (work, money, family, health, etc)? How do you deal?

What is your present activity level? What kind of exercise? Duration?

Do participant in any mindful or stress relieving activities - meditation, yoga, journaling, prayer?

What is your present occupation? Former occupations? Work schedule? Activity level at work?

Dietary Choices and Eating Habits 🥑

Tell me about your regular food choices and eating habits. Please elaborate where possible.

Meal pattern (i.e. breakfast in car, bagged lunch at desk, snack when in the door, dinner with family, etc). What do you like for/typically have for breakfast, lunch, dinner, and snacks? Do you have a tendency to skip meals? How often do you eat out? Do you graze?

Food weakness or cravings? (carbs, fried, spicy, alcohol, sugar, baking, chocolate, salty, etc.)

Tell me about your liquid intake; how much water, what other beverages? coffee, pop, alcohol?

Who does the grocery shopping at home? Who does the cooking? How often do you cook?

Item	List Your Likes/Dislikes	Form (circle)	How Often?
Vegetables	Like/Typical Choice: Dislike:	salad, raw, steamed, boiled, baked, fried	
Fruit	Like/Typical Choice: Dislike:	fresh, canned, juice, dried	
Beans / Legumes	Like/Typical Choice: Dislike:	dried, canned, dips, milk, tofu	
Nuts / Seeds	Like/Typical Choice: Dislike:	raw, roasted, salted, butters, trail mix, bars	
Grains	Like/Typical Choice: Dislike:	white, whole, bread, pasta, baking, cereals	
Dairy	Like/Typical Choice: Dislike:	milk (skim, 1%, 2%, homo) cheese (hard, soft); yogurt (full fat, no fat); cow, goat	
Dairy substitute	Like/Typical Choice: Dislike:	milk, cheese, yogurt rice, almond, hemp, soy	
Animal Protein / Seafood	Like/Typical Choice: Dislike:	commercial, free range, wild, roast, steak, deli meat, canned, eggs	
Snacks	Like/Typical Choice: Dislike:		
Eating Out	Typical Locations: Typical Choices:		
Beverages	Like/Typical Choice: Dislike:		
Spices and Condiments	During Cooking: Sauces/Dips:		
Sweeteners	For Cooking/Baking: For Tea/Coffee: For Cereal/Oatmeal/Pancakes:		
Fats and Oils	For Cooking/Baking: As a Spread: In Salad Dressings:		