

JLDFIT

Initial Client Intake Health History

Name _____ Birthday _____ Age _____

Height _____ Weight _____ Desired Weight goal (if applicable) _____

When's the last time you remember feeling really great? Finish this sentence for me, "I haven't felt great since..." _____

What are your primary concerns? These concerns can be physical, emotional, and spiritual.

Symptoms

Describe your symptoms and their location. _____

Describe your symptoms on a good day: _____

Typical Day: _____

Worst Day: _____

When did it begin? _____

What makes it better or worse? _____

Have you seen a Naturopathic Doctor or Holistic Nutritionist for this symptom, if so what was the treatment and did it work? _____

What was going on in your life when the symptoms began? _____

Have you had Intolerance Testing? If so, please list allergens and intolerances.

How much water do you drink daily? _____

Do you have Amalgam fillings? If so, how many? How long have you had them? _____

Have you received vaccinations? How Many? How Long Ago? _____

How many antibiotics have you used in the last year? _____

Last 5 years? _____ Lifetime? _____

List major surgeries and years it was performed _____

Any missing Body parts or organs? _____

Any major past trauma to the body? _____

Any major shift in Life circumstance within the last 5 years? _____

List of current medications _____

List of Supplements if taking any _____

Happiness

Scale of 1 to 10 (1 being worst, 10 being best) rate the following:

_____ Waking energy level _____ Evening Energy Level
_____ Personal happiness level _____ Work
_____ Family & relationships

Who or What makes you the happiest? _____

What makes you laugh? Do you laugh every day? How many times each day? (Remember 300 is the goal) _____

Sleep

Total hours of sleep? _____ Total hours of uninterrupted sleep? _____

If you have disturbed sleep, what is the time of the disruption? _____

Do you dream? _____ Do you remember your dreams? _____

How long does it take to fall asleep? _____ Do you wake refreshed? _____

Digestion

What is your average number of bowel movements per day? _____

Do you have any days without a BM each week? _____

Do you have a BM within 2 hours of waking up? _____

Are your B/M complete? _____ Well formed? _____ Any blood? _____ Any mucus? _____

Mark all that apply

_____ dark circles under the eyes	_____ acne
_____ eczema	_____ history of asthma/sinusitis
_____ sore throat/stiff neck	_____ history of hernias
_____ history of acid reflux	_____ history of migraines
_____ history of ear itching/infections	_____ fatigue 2+ hours after eating
_____ itchy eyes	_____ nosebleeds
_____ history of irritable or inflammatory bowel	

Myofascial / Neurological (mark all that apply)

_____ back pain	_____ shoulder pain
_____ neck pain	_____ sciatica
_____ carpal tunnel syndrome	_____ TMJ syndrome
_____ numbness/tingling	_____ seizures
_____ muscle pain that moves from place to place	

Male Reproductive (if applicable, mark all that apply)

_____ diminished urinary stream _____ difficulty achieving erection
_____ difficulty maintaining erection

Are you on Hormones or hormone replacement therapy? _____

Female Reproductive (if applicable, mark all that apply)

Menstrual cycle is: _____ regular (4-6 days) _____ long _____ short _____ none

Menstrual flow is: _____ regular _____ heavy _____ light _____ none

Are you on Hormones or hormone replacement therapy? _____

Acidity & Nutrient Deficiencies (mark all that apply)

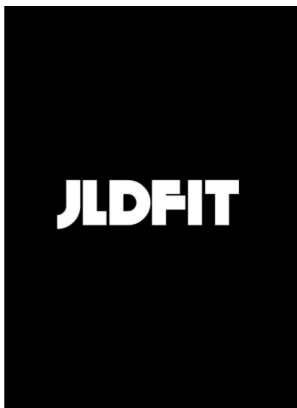
- | | |
|--------------------------|-----------------------------|
| _____ red eyes | _____ sensitive skin |
| _____ hyperthyroidism | _____ hypothyroidism |
| _____ brittle nails/hair | _____ multiple broken bones |
| _____ clear urine | _____ arthritis |
| _____ easy bruising | _____ slow reflexes/recall |
| _____ cavities | _____ high blood pressure |
| _____ low blood pressure | _____ heart palpitations |
| _____ kidney stones | _____ high cholesterol |

Digestive (mark all that apply)

- | | |
|---|---------------------------|
| _____ constipation | _____ diarrhea |
| _____ alternating diarrhea & constipation | _____ nausea |
| _____ vomiting | _____ easy dizziness |
| _____ acid reflux | _____ hemorrhoids |
| _____ hernias | _____ flatulence |
| _____ rectal bleeding | _____ rectal itching |
| _____ history of ulcers | _____ mucus in stools |
| _____ undigested food in stools | _____ clay colored stools |

Emotion (check all that apply)

- _____ Fire: unworthy/resistant to change/accepting of defeat
- _____ Earth: busy as escape/excessive concentration/mental chatter/easily overwhelmed
- _____ Gold: grieving/keeping it inside/can't let go
- _____ Water: lack of trust /afraid/worried/anxious
- _____ Wood: angry/indecisive/frustrated/impatient/complaining/timid
- _____ Accessory Fire: alone/isolated/neglected/guilt/excessive thought/second guessing self



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