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

**Digestive (mark all that apply)**

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

JLDFIT

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