

HEALTH AND BODY RESTORATION INTAKE FORM

Client Name _____ Today's Date _____

Age _____ Birthday _____ Email address _____

Address _____

Best phone number to contact you _____

Please provide health history with current/past diagnosis, **starting with most recent complaint**. (All information is protected by privacy laws and is kept confidential).

(Feel free to write on back of this page if necessary)

Please list any medications and/or vitamins you currently take:

	Dose	Frequency		Dose	Frequency
1.	_____	_____	6.	_____	_____
2.	_____	_____	7.	_____	_____
3.	_____	_____	8.	_____	_____
4.	_____	_____	9.	_____	_____
5.	_____	_____	10.	_____	_____

(Please list on back side of this page if you need more space)

Of bowel movements/day _____ # caffeinated drinks/day _____ #alcoholic drinks/week _____
Ave. hours sleep/night _____ How often do you exercise/week? _____ Are you in pain? _____
If so, Where? _____ Is it getting worse? _____ How long have you had this? _____
Do you read labels? _____ How often do you eat out/week? _____

WHAT ARE YOU WILLING TO DO TO GET AND STAY HEALTHY?

Exercise _____ Take supplements? _____ Change your eating Habits? _____ and Life style? _____
Come in for regular checkups? _____ Do Simple tests at home to monitor your progress? _____

Do you believe your body can heal and recover? _____ What are your health goals? _____

HOW LONG DO YOU THINK IT WILL TAKE TO ACCOMPLISH YOUR GOALS?

Days? _____ Weeks? _____ Months? _____ Years? _____

WHAT DO YOU EXPECT ME TO DO TO HELP YOU ACCOMPLISH YOUR GOALS?

Figure out what changes are needed and make recommendations? _____ Monitor your health and
make sure you are progressing? _____ Show you what you can do to help yourself _____
Do everything for you? _____