



Enhance Nutrition, LLC
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Client Intake Form

Personal Information

Name:		Date:
Birthdate:	Age:	Gender:
Height:	Weight:	
Address:	City:	State: Zip:
If a minor, provide parent name(s):		
Email:		
Home Phone:	Work Phone:	Cell Phone:
Check box for preferred phone number to contact you		
Employer/Occupation:		
Ethnic background:		
Relationship status:	Married	Single Divorced Widow/ Widower Other:
Emergency Contact Name & Phone number:		
Do you have children?	Y N	Ages?
Do you have pets?	Y N	What type and how many?
Primary Care Physician name and phone:		
How did you hear about me?	Workshop/ Seminar	Business Card Website
Referred by:		

Health & Wellness

Reason for visit?

Please list or attach any test results from a doctor such as blood, urine, etc.

What are your primary health and wellness concerns and/or goals?

Are there any obstacles or challenges that you believe make it difficult to achieve your health and wellness goals?

Have you previously utilized nutritional or lifestyle protocols to improve your health and wellness, and if so what were they and what were your results?



Indicate below if you or an immediate family member have or had any of the following conditions:

Condition	Self	Family	Condition	Self	Family
Cardiovascular			Muscular, Skeletal, Joints		
High blood pressure			Joint Pain, stiffness, swelling		
Low blood pressure			Frequent muscle cramps		
High cholesterol			Osteoarthritis		
Heart attack or stroke			Rheumatoid Arthritis		
Arrhythmia			Osteoporosis/Osteopenia		
Digestive/ Gastrointestinal			Endocrine		
Acid reflux/heart burn/indigestion			Diabetes Mellitus Type 1		
Colitis			Diabetes Mellitus Type 2		
Hiatal hernia			Hyperglycemia		
Celiac disease			Hypoglycemia		
Irritable Bowel Disease, IBD			Thyroid disorder		
Irritable Bowel Syndrome, IBS			Adrenal disorder		
Genital/Urinary			Liver/Gall Bladder		
Frequent yeast infections			Hepatitis		
Urinary tract infections			Cirrhosis		
Kidney stones			Gall stones		
Kidney or bladder disease			Viral/ Bacteria infections		
Neurological/ Mental Status			HIV/AIDS		
Anxiety or Depression			Sexually transmitted disease		
Migraines			Lyme disease or other tick-borne illness		
Dementia/ Alzheimer's			Frequent strep throat		
Multiple Sclerosis (MS)			Other Conditions		
Parkinson's Disease			Cancer, if so, type:		
Fibromyalgia					
Respiratory/ Ear, Nose, Throat					
Sinusitis			Food allergies or sensitivities		
Ear infections/ tubes in ears			Seasonal/environmental allergies		
Chronic obstructive pulmonary disease (COPD)			Chemical sensitivity		
Chronic bronchitis			Anemia/ blood condition		
Asthma			Alcohol or substance abuse		
Emphysema			Epilepsy or seizures		
Frequent colds, infections			Eating disorder		
Menstrual			Skin condition (eczema, dermatitis, psoriasis, acne)		
Painful periods			Obesity/ overweight		
Irregular/ absent periods			Gout		
Heavy periods/ excessive bleeding			Chronic Fatigue syndrome		
Premenstrual syndrome (PMS)			Female hair growth on face/ chest		
Endometriosis			Dental/ periodontal problems		
Other not listed:					



Mark the circle for each condition below signifying your level of severity from “0” being never to “5” being always.

	0	5		0	5
Constipation			Cannot fall asleep		
Diarrhea			Cannot stay asleep		
Pass large amounts of foul smelling gas			Insomnia		
Laxative use			Slow starter in the morning		
Excessive burping, gas or bloating			Afternoon fatigue		
Gas immediately after a meal			Dizziness when standing up quickly		
Sense of fullness during & after a meal			Afternoon headaches		
Nausea			Perspire easily		
Undigested food found in stool			Under high amounts of stress		
Heartburn when lying down or bending forward			Weight gain when under stress		
Antacid use			Wake up tired even after 6 + hours of sleep		
Specific foods cause heartburn			Tired, sluggish		
Greasy/high fat foods cause distress			Feel cold – hands, feet, all over		
Crave sweets during the day			Gain weight easily		
Irritable if meals are missed			Thinning hair on scalp, face, genitals		
Eating relieves fatigue			Dry skin		
Fatigue after meals			Mentally sluggish		
Eating sweets doesn't relieve sugar cravings			Heart palpitations		
Must have sweets after meals			Nervousness/highly emotional		
Crave salt			Night sweats		
Crave chocolate			Difficulty gaining weight		



Women's Health

Regular periods? Y N Age started: _____ Are you peri-menopausal post-menopausal?
 Date of last period: _____ If so, symptoms/ concerns?
 Concerns?
 Do you take birth control pills? Y N Are you using bio-identical or synthetic hormones?

Men's Health

Do you have prostate issues/ concerns? Y N Do you have erectile concerns? Y N
 Describe: _____ Describe: _____

Treatments, Medications & Supplements

Are you currently being treated for a medical condition? Y N Condition(s)? _____
 List any prescription/OTC medications you are currently taking:

Vitamin, mineral or other supplements (e.g., probiotics, herbs, etc):

Allergies or sensitivities (food, drugs, seasonal, chemical, other):

Recent immunizations/vaccinations?	When did you last take an oral antibiotic?
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Eating Habits & Food Intake

How many times per week do you eat out, or bring home take-out food?

Do you eat packaged or frozen foods? Y N How often?

Do you typically eat breakfast? Y N	How many meals do you eat per day?
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How many times a day do you snack?	Please provide examples of your typical snack:
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Do you drink alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N Type & how much per day/ week?	Do you smoke cigarettes or cigars? <input type="checkbox"/> Y N How many/day?
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What are the foods you eat most frequently in a given week?

Do you frequently feel thirsty? <input type="checkbox"/> Y <input type="checkbox"/> N	What do you drink most in a given day? How much water do you drink?
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Do you often feel hungry? <input type="checkbox"/> Y N	Do you eat beyond feeling full? Y N
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Reflect on what you think the “triggers” are to your eating outside of basic meals and snacks, (e.g. stress, fatigue, boredom, joy, nervousness).

Are there any foods will you NOT eat?

Indicate all that apply to your current state of being, lifestyle and eating habits

<i>Eat too much</i>	<i>Love to eat</i>
<i>Erratic eating patterns</i>	<i>Frequent colds, illness</i>
<i>Eat on the run, travel frequently</i>	<i>Poor focus, memory, attention</i>
<i>Emotional eating</i>	<i>Do not plan meals or menus ahead</i>
<i>Late night eating</i>	<i>Rely on convenience/ fast foods</i>
<i>Fast eater</i>	<i>Often eat/ drink for business or social occasions</i>
<i>Skip meals</i>	<i>Confused about what to eat</i>

Lifestyle, Exercise, and Sleep

Describe your typical daily energy level?
 Low Average High

Do you engage in regular physical exercise? Y N
 Type & frequency:

What is your current stress level?
 Low Average High

Any physical conditions which limit your ability to exercise?
 Y N Describe:

What causes you stress?

How many hours do you sleep per night?
 Do you wake feeling rested? Y N

What do you do to relieve stress?

Is there anything else you would like to share?



Informed Consent

- *Nutrition and exercise are intended to promote general health and wellness and are not intended to replace physician care or medical intervention. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input, and are not intended to diagnose, treat or cure any disease or ailment*
- *You accept all responsibility for reviewing diet, nutrition, lifestyle or exercise suggestions with a licensed medical professional before following said suggestions.*
- *Any activity or program may have inherent risks, which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself. You agree to inquire about any activities with which you are not familiar, and provide any information which may limit your participation in suggested activities.*
- *Results and changes in your general health and wellness may vary depending on medical conditions, medications, and accuracy in following suggested guidelines.*
- *As your general health and wellness may change with modifications in diet, nutrition and lifestyle, physician prescribed medications may require modification. It is your responsibility to discuss this with your physician. Never reduce or eliminate physician prescribed medications without the direction of your physician or medical care provider.*
- *Your personal and health information will remain confidential and will not be shared without your consent. You give permission for the information provided on this form and discussed in your nutritional consultation(s) to be shared and discussed with the primary care physician you have listed on this form, at the discretion of the nutritionist and in the interest of your general health and wellness.*
- *Marcy Kirshenbaum and Enhance Nutrition, LLC reserve the right to refuse services to any individual.*

Payment is due at the time of service.

Please call at least 24 hours ahead of time if you must cancel an appointment. There is a \$75 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours notice.

The provision of services, work product, advice and the delivery of supplements may be suspended due to lack of payment. Returned check fee of \$25.

Print Name: _____

By signing below, you agree to the above terms and conditions for participation in nutritional consultation with Marcy Kirshenbaum and Enhance Nutrition, LLC.

Signature: _____

Date: _____