Intake Form

Kristi Lea Holistic Health LLC

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_

Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_

Your Health Concerns Any Diagnosis/When Medications/Supplements

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**Please circle and indicate the frequency of any symptom. \_\_= Never, 1= Sometimes, 2= Almost always, S= Severe**

**Digestion / Pancreas / Liver / Gallbladder**

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| --- | --- | --- | --- |
| Gas/Bloating/Indigestion | Gallbladder attacks/Removed | Loss taste for meat | Vegan/Vegetarian |
| Acid Reflux | Use Zantac/Prilosec/Tums etc | Pulse speeds after eating | Eats fast food |
| Intestinal pain | Sleepy after meals | Hemorrhoids | Consumes alcohol |
| Constipation | Stomach upset by taking vitamins | Intestinal pain | Easily intoxicated/hung over |
| Uses laxatives regularly | Blood or mucous in stool | Foul smelling gas | Consumes Gluten/Dairy/ Sodas |
| Diarrhea shortly after meals | Light or clay colored stool | Varicose veins | Sinus Congestion |
| Stool has corners, ridges, flat or ribbon like | Undigested food in stool | Bad breath/strong body odor | Diverticulitis |
| History of motion or morning sickness | Greasy or shiny stool | Dark circles under eyes | Autoimmune issues |
| Nausea/ feel worse after eating | Pain between shoulder blades | Feel like skipping breakfast | Coated tongue |
| Stomach upset by greasy food | Hypoglycemia | Chemical hypersensitivity | Asthma/ exercise induced asthma |
| Pain under right rib cage | Overweight; especially in middle | Dry, cracked heels, skin | Chronic fatigue/ exhaustion |
| Allergies/ Rashes/ Acne | Family history of heart disease | Taken prescriptions regularly | Crave sugar |
| Diabetes I or II | High blood pressure/cholesterol | Excessive appetite | Need to snack frequently |
| Irritable/ “Hangry” if meals are delayed | Shaky/lightheaded/weakness if meals are delayed | Headache if meals are delayed | Feel better after eating |
| Yeast symptoms increase with sugar or alcohol consumption | Painful to press along outer thighs (illiotibial bands) | 1 or more bowel movements daily | Eat 5 servings of fruit and vegetables a day |

**Cardiovascular**

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| --- | --- | --- | --- |
| Stroke or heart attack | Air hunger/sigh frequently | Ankles swell | Cough at night |
| Enlarged heart/ congestive heart failure | Aware of heavy or irregular breathing | Muscle fatigue/ cramps with exertion | Blush or face turns red for no reason |
| Dull pain or chest tightness | Slow or weak pulse | Irregular heartbeat/ heart races | Sleep apnea |
| Family History of high blood pressure | Heart palpitations | Shortness of breath/ feel exhausted with moderate exertion | Can hear heartbeat on pillow |

**Vitamin and Mineral needs**

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| --- | --- | --- | --- |
| Stinky feet | Loss of muscle tone | Cold sores, fever blisters or herpes lesions | Vulnerable to insect bites |
| Decreased sense of taste or smell | Numbness/tingling in hands and feet | Joints pop, click | Pain or swelling in joints |
| Cracks in corners of your lips (Cheilosis) | Ringing in the ears (tinnitus) | History of bone spurs | Calf, foot or toe cramps at rest |
| Restless leg syndrome | History of anemia | Morning stiffness | Hoarseness |
| Night sweats | Carpal tunnel syndrome | Bleeding gums when brushing teeth | Crave chocolate |
| Whole body jerks as falling asleep | Strong light at night irritates eyes | Difficulty swallowing | Bursitis or tendonitis |
| Small bumps on back of arms | Birth defects in children | Gag easily | Excessively flexible joints |
| Poor night vision | Bone loss /osteopenia /osteoporosis | White spots on fingernails | Dry mouth, eyes and/or nose |
| Arthritis | Arteriosclerosis | Polyps or warts | Skin rashes |
| MTHFR snps | Heavy metal toxicity | Lump in throat | Low vitamin D level |
| History of dental cavities, root canals, crowns, dentures, gum disease | Wake up without remembering dreams | Shorter than you used to be | Nosebleeds/bruise easily |

**Histamine intolerance**

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| --- | --- | --- | --- |
| History of nosebleeds | Difficulty falling asleep | Unable to tolerate Ibuprofen | Cannot tolerate seafood |
| History of chronic hives/rashes | Anxiety | Anaphylaxis reactions | Exercise induced asthma |
| Facial or limb swelling | Frequent headaches /migraines | Bug bites turn into large, itchy welts | Flushing or warmth with alcohol |
| Acid reflux/intestinal pain after eating | unable to tolerate red wine, salad bars, alcohol | Cannot tolerate fermented foods | Unable to tolerate leftovers |
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**Sleep**

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| Difficulty falling asleep | Difficulty staying asleep | Awaken without feeling rested | Awaken at the same time every night |

**Adrenals/ Emotional Stress**

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| Big reaction if startled | Always feel cold | Calm on the outside, troubled inside | Tendency to need sunglasses |
| Phobias /PTSD /severe stress /anxiety | Tend to be a night owl | Clench or grind teeth | Pain on inner side of knee(s) |
| Difficulty falling asleep | Slow starter in the morning | afternoon exhaustion /headache | Low blood pressure |
| Chronic fatigue /drowsy frequently | Low blood pressure | Become dizzy when standing up suddenly | Chronic low back pain |
| Crave salty foods | Irritability/anxiety/nervousness | Hypoglycemia | Poor memory /concentration |
| Anxiety | Depressio0n | Difficult relationship(s) | Stressful job |
| Impacted by alcoholism or addiction | Acute childhood stress(es) | Feel need to be sneaky or tell “white lies” | Feel like a victim |
| Impacted by mental illness | Low self-esteem/ self -worth | Have to please others excessively | Rarely touch or get touched |
| Unable to allow yourself to relax or have fun | Severe phobias or fears that limit you | Unable to confront or say no without guilt | Unable to express sadness, fear or anger |
| Unable to ask for what you need or want | Unable to forgive yourself/others | Unresolved anger, bitterness or resentment | Addictions to alcohol, drugs, sex, work, food, etc. |
| Slow recovery from stress , infections, trauma, surgery, exercise | Lonely, isolated, lacking meaningful relationships |  |  |

**Thyroid**

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| --- | --- | --- | --- |
| Weight gain/loss | Coarse hair/dry skin | Depression | Flush easily |
| Difficulty losing weight | Forgetful | Decreased libido | Intolerant to high temperatures |
| Excessive fatigue | Cold hands & feet/Always feel cold | Insomnia | Mood swings/ emotional |
|  | Constipation | Loss of lateral 1/3 of eyebrows | Seasonal sadness |

**Kidney/Bladder**

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| Pain in mid-back region | History of kidney stones | Puffy around the eyes | Dark circles around the eyes |
| Cloudy, bloody or darkened urine | Bubbles or frothy urine | Retaining water | Urine has a strong odor |

**Immune system**

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| --- | --- | --- | --- |
| History of Epstein Barr/ Mono | Yeast overgrowth | Chronic inflammation | Diabetes |
| Chronic fatigue syndrome | Frequent colds or flu | Coated tongue | Multiple Sclerosis |
| Hashimoto’s/ Grave’s disease | Lupus | Eczema/ Psoriasis | History of Lyme disease |
| Rheumatoid arthritis | Ulcerative Colitis | History of fibromyalgia | Frequent infections (sinus, UTI, strep, ear infection) |

**Women**

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| --- | --- | --- | --- |
| PMS | Can focus on a task for hours | Thinning skin | Painful intercourse |
| Irregular periods | Prone to anxiety or depression | Miscarriage(s) # | Vaginal discharge |
| Heavy, clotty periods | Abnormal pap smear | Headaches with birth control pill | Hot flashes |
| Migraines | Crave chocolate | Clotting disorder (Factor 5) | Night sweats |
| Uterine fibroids | Breast tenderness | Difficulty falling asleep | Weight gain around the middle |
| Excess facial or body hair | Skipped or absent periods | Cancer diagnosis | Hysterectomy |
| Menopause | Vaginal dryness | Infertility | Adrenalin junkie |
| Morning sickness in pregnancy | Endometriosis | Breast fibroids | Craves carbs |
| Family history of cancer/hysterectomy | Sexually transmitted disease | Neurological symptoms with birth control pill | Abuse in the home: physical, emotional, sexual, financial, verbal |

**Men**

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| --- | --- | --- | --- |
| Prostate problems | Erectile dysfunction | Decreased libido | Waking up to urinate |
| Autoimmune diagnosis | Interrupted stream during urination | Cancer diagnosis | Sexually transmitted disease |
| Difficulty with urination; dribbling | Abuse in the home: physical, emotional, sexual, financial, verbal |  |  |

**Background information**

**For your mother’s pregnancy with you…**

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| --- | --- |
| Were there any complications in pregnancy and birth? | Were you born vaginally or Cesarean? |
| Were you a healthy baby? | Were you breastfed? |
| How was mom’s dental during the pregnancy with you? Fillings/ cavities/Crowns/Root canals/ Dentures/ Extractions | Do you have a history of…Strep throat/ asthma or ear infections? |
| Mom’s health history: | |
| Dad’s health history: | |
| Grandparent’s Health: | |
| Grandparent’s Health: | |
| Grandparent’s Health: | |
| Grandparent’s Health: | |
| Sibling’s health history: | |
| Additional information: | |
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