Wendy Blanchard, M.S., CHHC, CPS | 845-263-4094 | Wendyblanchard044@gmail.com

INTAKE FORM

Please type or print clearly. All of your information will remain confidential between you and your Health Counselor.

PERSONAL INFORMATION

First Name: _____ Last Name: _____

E-mail: _____

Phone: Home: _____ Work: _____ Cell: _____

Age: _____ D.O.B.: _____ Birthplace: _____

Height: _____

Current Weight: _____ Weight Six Months Ago: _____ One Year Ago:_____

Would you like your weight to be different? _____

If so, what? _____

SOCIAL INFORMATION

Relationship Status: _____

Family/Living Situation: _____

Have you or your family recently experienced any major life changes/losses in the last 2-3 years? If so, please comment: _____

_____

Where do you currently live? _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

HEALTH INFORMATION

Please list your main health concerns for which you would like to explore solutions to promote wellness: _____

_____

_____

When did this begin? How have you dealt with these concerns? _____

_____

Other concerns and/or goals? _____

_____

At what point in your life did you feel your best? _____

_____

Any serious illnesses/hospitalizations/injuries? _____

_____

What other health practitioners are you currently seeing? _____

Primary Care Physician name/phone: _____

Please list any medications/supplements/vitamins that you are currently taking: _____

_____

NUTRITIONAL STATUS

Are there any foods that you avoid because of the way they make you feel? (Bloating, Gas, Sneezing, Hives?) _____

Please describe your current diet. Do you eat foods containing gluten, dairy, GMOs, sugar, processed foods? _____

Do you consume soda, alcohol, fast foods, coffee? _____

How often do you eat out? Cook at home? _____

Is there anything else I should know about your nutritional health? Allergies? Eating Disorder?

_____

INTESTINAL STATUS

Number of bowel movements per day?

◯ 1-3 ◯ More than 3 ◯ Do not have a regular bowel schedule

Bowel movement consistency

☐ Soft & well formed ☐ Often floats ☐ Difficult to pass ☐ Diarrhea

☐ Long/Thin/Narrow ☐ Small and hard ☐ Loose but not watery ☐ Alternates

Bowel movement color: _____

Any signs of blood in your stool? _____

MEDICAL STATUS

Please list any medical conditions for which you are being treated, length of treatment, type of treatment, and any other pertinent information: _____

_____

_____

Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?:

_____

LIFESTYLE

Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Please give any pertinent details: _____

_____

What are your current self care practices? How often? (Daily? Weekly? Not at all?) _____

_____

_____

Describe your sleep patterns. Can you get to sleep easily? Can you stay asleep? How many hours do you average per night? _____

_____

Meditation/Prayer practice? Religious practice/Affiliation? _____

Type of friendships/relationships with whom you engage regularly: Please tell me about these relationships: _____

_____

FOR WOMEN ONLY:

Menstruation Cycle: ◯ Normal? ◯ Other? Please describe: _____

MENTAL HEALTH STATUS

Are you experiencing any symptoms of excessive anxiety, depression, anger, suicidal thoughts, self harming behaviors? _____

For how long? _____

What have you been doing, if anything, to treat your symptoms? _____

_____

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy: _____

GENERAL INFO

Please share any other information that you feel will be helpful as we work to reach your health and wellness goals: _____

_____

Will you have family/friend/other support as you begin your wellness work? _____

_____

Please think about what your top 3 (three) health and wellness goals are at this time. You can always add/delete later. Number 1 being your top priority, and so on.

1. _____

2. _____

3. _____

TODAY'S DATE: _____

SIGNATURE: _____