**New Client Intake Form** **Today's Date** ________________________

**(Please Print)**

Name ________________________________________ Phone____________________

Address ________________________________________________________________

City __________________________ State ________ Zip Code _________________

Email Address __________________________________________________________

Occupation _______________________ DOB ________________ Age __________

Married: Yes / No Gender: Male / Female Height: _________ Weight: _______

Referred by _____________________________________________

**Please list below your four main health complaints:**

1)____________________________________________________________

2)____________________________________________________________

3)____________________________________________________________

4)_____________________________________________________________

History of Illnesses and Treatments: ______________________________________________

____________________________________________________________________________

Operations, Accidents or Injuries: ________________________________________________

____________________________________________________________________________

Family History of Illnesses or Disease: ____________________________________________

____________________________________________________________________________

Medications and/or Supplements: _______________________________________________

____________________________________________________________________________

**Client Signature** _______________________________________ **Date** _________________

1. Are you currently under the care of a medical doctor? Yes / No

2. Have you had routine blood work done in the last 12 months? Yes / No

3. Were there any elevated blood results? If so, please list (ie, cholesterol, etc) ___________
_______________________________________________________________________________________

4. Do you have daily bowel movements? Yes / No If no, how often? ___________________
Choose the consistency Pudding Pebbles Happy Bananas

5. Do you experience gas or bloating? Yes / No

6. Do you experience GERD (acid reflux)? Yes / No

7. How many glasses of water do you drink per day? ___________

Circle all that apply: Filtered Bottled Tap Sparkling

8. How often do you get up to pee during the night? ___________

9. Do you experience headaches? If so, choose Sinus Tension Migraine Cluster

10. How many hours of sleep do you get per night on average? _________

11. Do you have children? If so, how many and what are their ages? _____________________

12. Do you experience anxiety? Please Choose: Daily Sometimes Rarely

To what degree? Mild Moderate Panic Attacks

13. Have you ever been diagnosed with depression? Yes / No

14. Have you lost a loved one or close friend in the last 2 years? Yes / No

Relation: _____________________________

15. Have you moved or changed jobs in the last 2 years? Yes / No

16. Have you been through a divorce or recently married in the last 2 years? Yes / No

17. Have you ever received a Flu shot? Yes / No

18. Are you on Birth Control Pills? Yes / No

19. Are you on hormone replacement therapy? Yes / No

20. **Please circle all that apply:**

| | | |
|---|---|---|
| Seasonal allergies | Food allergies (list) ________________________ | Other ______________ |
| Asthma | Sinus congestion / infections | Urinary Tract Infections |
| Gout | Stomach Ulcer | Brain Fog |
| Kidney Stones | Gall Stones | Toe Fungus |
| Yeast Infections | Thrush | Irregular Periods |
| IBS | Back Pain | Neck Pain |
| Arthritis | Heart Palpitations | Heart Disease |
| Organ Transplant | Miscarriage | Hair Loss |
| Cold hands/feet | Low body temp | Low / High Blood pressure |
| Insomnia | Fatigue | Weight Gain / Weight Loss |

21. I have all the energy I need    I have some energy    I am exhausted most of the time

22. I do not feel stressed at all    I experience some stress    I feel overwhelmed

23. I am happy with my nutrition    I am unhappy with my nutrition    I am open to changes

24. I am happy with my weight    I would like to lose ______ libs

25. Please let me know what you would like to get out of this wellness session today?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Disclaimer:**
Dr. Leslie Shew is not a medical doctor and does not diagnose nor treat disease. Wellness sessions are intended for educational purposes only. Nutritional suggestions and supplements are not to be used as treatment for disease. Please consult with your medical doctor for diagnosis and treatment. Do not stop any prescription medications without the direct advice of your medical doctor. Herbal and nutritional supplements have not been evaluated nor approved by the FDA.