CLIENT INTAKE FORM

Please answer the following questions to the best of your knowledge as it will help me conduct a thorough evaluation of your health goals. All of the information provided is confidential. If you have any questions, please do not hesitate to ask. Thank you.

HOW DID YOU HEAR ABOUT US?

□ Referral

□ Community, online advertising, social media etc.

□ Other (Please specify)

ABOUT YOU

NAME: _____ DATE: _____
(First) (Last)

DATE OF BIRTH: _____ PLACE OF BIRTH:_____
dd / mm / yy city / country

AGE: _____ GENDER:_____

ADDRESS:_____ _____
Street apt. # city postal code

PHONE: (home):_____ (work):_____

EMAIL:_____

CELL: _____ OCCUPATION:_____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

DOES YOUR EXTENDED HEALTH CARE PLAN COVER **HOLISTIC NUTRITION** SERVICES? □ YES □ NO

WOULD YOU LIKE TO BE INCLUDED ON OUR EMAIL LIST FOR THE LATEST NEWS AND UPDATES? THESE GO OUT 1-2X/ MONTH

□ YES PLEASE!

□ NO THANKS

MAIN CONCERNS & GOALS

1. _____

2. _____

3. _____

Have the conditions above been diagnosed? By who?_____

Have these conditions been treated? How?_____

Was it successful?_____

Are you currently on any **medications?** Please include over the counter drugs and antibiotics.

Medication (include dose)	**Illness/reason**

Are you taking any **supplements or remedies** at the present time? (E.g. homeopathics, vitamins, herbal medicines)

Supplement (include dosage)	**Illness/reason**

Do you smoke?
□ YES □ NO If yes, how long?_____ How much? _____

Do you Consume Alcohol? If yes, how much/many drinks per week?_____
□ YES □ NO

Do you exercise? If yes**,** what do you typically do? (explain below):
□ YES □ NO

_____

_____

_____

Do you use recreational drugs? □ YES □ NO

If yes, indicate type, frequency, duration of use

_____

_____

Do you have any **allergies or sensitivities**? □ YES □ NO If yes, or please circle applicable items:

Citrus	Strawberries	Pollen
Dairy products	Nuts	Mould
Wheat	Penicillin	Bees
Gluten	Aspirin	Animal dander
Soy	Tylenol	Anything else? _____
Eggs	Dust	

How would you rate your **energy** at this time on a scale of 1 - 10? (1-very low 10- exceptional)

1 2 3 4 5 6 7 8 9 10

Have you ever had surgery, been hospitalized, or suffered major injuries? □ YES □ NO

If yes, please provide details?

_____

MEDICAL HISTORY:
Please indicate which, if any, of the following conditions you may have experienced:

Allergies
Abscesses
Alcoholis
Anemia
Anxiety
Arthritis

Asthma
Bronchitis
Cancer
Chicken pox

Cold Sores
Cough
Depression
Diabetes
Eczema
Emphysema
Epilepsy
F r e q u e n t
colds
Gallstones
Gout

Hay Fever
Hearing loss
Heart disease (CHF)
Herpes
HIV
Influenza
Insomnia
Kidney stones/disease
Low/High Blood Pressure
Lyme disease
Malaria
Measles
Migraines/Headaches
MS
Mumps
Pace maker or similar
Parasites
Peritonitis
Pelvic Inflammation
Disease
Pneumonia
PMS

Pregnancy
Prostatitis
Shortness of breath
Sinusitis
Stroke/CVA
Strep throat
Thyroid
Tonsillitis
Tuberculosis
Varicose veins
Vertigo
Vision problems

Other: _____

FAMILY MEDICAL HISTORY

Please circle any conditions that have affected your **parents, siblings, or grandparents**. Please specify whom condition affected in comments section if applicable:

Alcoholism	Depression	Hepatitis	Thyroid disease
Arthritis	Diabetes	HIV	Glaucoma
Asthma	Epilepsy	Lupus	Schizophrenia
Stroke	Hypertension	Tuberculosis	Herpes
Allergies	Eczema	Psoriasis	Anemia
Cancer	Hay fever	Parasites	Kidney disease
Cold sores	Heart disease	Rheumatic fever	Osteoporosis
Alzheimers	Goiter		

Additional Comments or Concerns

_____

_____

_____

_____

PATIENT CONSENT

I hereby attest to the following:

That I am here, on this and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial, municipal or professional agency on a mission of entrapment or investigation.

I fully understand that **Liz Cardoso** is not a medical doctor and I am not here for medical diagnostic or treatment procedures.

The services provided by **Liz Cardoso** are at all times restricted to consultation on the subject of nutritional matters intended for building wellness and does not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of any disease, or for any act for which a medical license is required.

In natural healing methods, it is not necessary to pinpoint disease. Nature heals when the body is normalized and natural foods and supplements are taken in place of toxin producing substances. We believe it is not important to name disease, but to focus on getting the individual educated and back on the right path to optimal health and well-being through proper nutrition and lifestyle habits.

CANCELLATION POLICY

I am aware that 24 hours notice (2 business days) must be given for all cancelled appointments or a cancellation fee (cost of appointment) will be applied.

I am aware there are no refunds for treatments & services received.

I also confirm that I have the ability to accept or reject these services/treatments of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency to gather information without stating. I accept full responsibility for any fees incurred during care and treatment.

This agreement is being signed voluntarily and not under duress of any kind.

_____

Name of Patient (Printed)

_____ _____

Signature Date