Intake Form

for a better you!

IRIDOLOGY READINGS

Today's Date:_____-_____-_____

Name:	Birthday:	Age:
Email:		
Address:		
City:	State:	Zip:
Cell:	Home:	Work:
Occupation:	Hours per week of work:	
Relationship Status:		
Children:	If so, their ages:	
Pets:	Types:	
Height:	Weight:	Weight One year ago:

Main Complaints: List your present health problems:

1. _____
2. _____
3. _____
4. _____
5. _____

At what point in your life did you feel bes t?_____

_____

What are your health goals? _____

_____

_____

Please list ALL medications or nutritional supplements you are currently taking:_____

_____

_____

_____

Health History:

List any surgeries or major i llnesses with approximate dates.

Illness: Dates: Recovered?:

_____

_____

_____

_____

List a ny family history of serious illnesses: circle all that apply.

Cancer: Type_____ Relation:_____

Diabetes: Type_____ Relation:_____

Heart Disease: Type:_____ Relation:_____

Other: _____ Type_____ Relation:_____

_____ Type_____ Relation:_____

_____ Type_____ Relation:_____

Please circle all that apply. Follow key below.
Key: 0=none symptom does not occur; 1=Yes, mild symptom, rarely occurs; 2=Moderate symptom, occurs weekly; 3=Severe symptom, occurs daily

Stomach:

0	1	2	3	Heartburn or Acid Reflux
0	1	2	3	Burping or Gas after eating
0	1	2	3	Bloating after eating
0	1	2	3	Bad Breath
0	1	2	3	Sweat has a strong odor
0	1	2	3	Feel better if I don't eat
0	1	2	3	Sleepy after meals
0	1	2	3	Burning pain in stomach
0	1	2	3	Fingernails chip/break/peel
0	1	2	3	Anemia Unresponsive to iron
0	1	2	3	Stomach pain or cramps
0	1	2	3	Diarrhea, chronic
0	1	2	3	Diarrhea after meals
0	1	2	3	Black or dark stool
0	1	2	3	Undigested food in stool
Total:				

Large Intestine:

0	1	2	3	Skip days between bowels movements
0	1	2	3	Stools hard or difficult to pass
0	1	2	3	Cramping on lower abdomen
0	1	2	3	Mucus in stool
0	1	2	3	IBS or colitis
0	1	2	3	Yeast infections
0	1	2	3	Nail fungus or athletes foot
0	1	2	3	Dark circles under eyes
0	1	2	3	History of parasites
0	1	2	3	Coated tongue
0	1	2	3	Anus itches
0	1	2	3	Constipation
0	1	2	3	Stools are loose
0	1	2	3	Bad smelling gas
Total:				

Small Intestine:

0	1	2	3	Food allergies
0	1	2	3	Bloating after eating
0	1	2	3	Airborne allergies
0	1	2	3	Wheat or gluten sensitivity
0	1	2	3	Dairy sensitivity
0	1	2	3	Sinus congestion
0	1	2	3	Craves bread/pasta
0	1	2	3	Pulse speeds after eating
0	1	2	3	Nightmares
0	1	2	3	Feel spacy or unreal
0	1	2	3	Alternating diarrhea/constipations
0	1	2	3	Hives
Total:				

Liver:

0	1	2	3	Nausea
0	1	2	3	Pain between shoulder blades
0	1	2	3	Skin rashes/acne/eczema
0	1	2	3	Age or “Liver” spots
0	1	2	3	Greasy foods upset stomach
0	1	2	3	Gallbladder attacks or stones
0	1	2	3	Motion sickness
0	1	2	3	Headache over eyes
0	1	2	3	Easily intoxicated
0	1	2	3	Hemorrhoids or varicose veins
0	1	2	3	Sensitivity to perfumes/chemicals/etc
0	1	2	3	Pain under right rib cage
0	1	2	3	Insomnia
Total:				

Mineral Deficiencies:

0	1	2	3	Carpal Tunnel Syndrome
0	1	2	3	Osteoporosis or Osteopenia
0	1	2	3	Legs or foot cramps at rest
0	1	2	3	Pain or swelling in joints
0	1	2	3	Bursitis or tendonitis
0	1	2	3	Joints pop or crack
0	1	2	3	White spots on fingernails
0	1	2	3	Decreased taste or smell
Total:				

Men’s Problems:

0	1	2	3	Prostate problems
0	1	2	3	Decreased libido
0	1	2	3	Urination difficult
0	1	2	3	Pain or burning with urination
0	1	2	3	Fatigue
0	1	2	3	Pain on inside of legs/heels
0	1	2	3	Feeling of incomplete bowel
Total:				

Please circle all that apply. Follow key below.
Key: 0=none symptom does not occur; 1=Yes, mild symptom, rarely occurs; 2=Moderate symptom, occurs weekly; 3=Severe symptom, occurs daily

Women's Problems:

0	1	2	3	Painful menstrual cycle
0	1	2	3	Mood swings around cycle
0	1	2	3	Painful breasts at cycle
0	1	2	3	Irregular cycles
0	1	2	3	Heavy menstrual flow
0	1	2	3	Acne at menstrual cycle
0	1	2	3	Yeast infections
0	1	2	3	Endometriosis
0	1	2	3	Uterine fibroids
0	1	2	3	Fibrocystic breasts
0	1	2	3	Hot flashes
0	1	2	3	Vaginal itchiness
0	1	2	3	Vaginal discharge
0	1	2	3	Night sweats
0	1	2	3	Menopausal symptoms
Total:				

Kidney and Bladder:

0	1	2	3	Pain upon urination
0	1	2	3	Frequent bladder infections
0	1	2	3	Cloudy, bloody, or dark urine
0	1	2	3	Urine has strong odor
0	1	2	3	History of kidney stones
0	1	2	3	Dribbling urination
0	1	2	3	Pain in lower back
Total:				

Immune System:

0	1	2	3	Catch cold/flu easily
0	1	2	3	Runny or drippy nose
0	1	2	3	Swollen lymph nodes
0	1	2	3	Gets boils, cysts, stys
0	1	2	3	Poor wound healing
0	1	2	3	History of Epstein bar, mono, herpes, shingles, or chronic fatigue
Total:				

Lyme Disease Traits:

0	1	2	3	Intense fatigue
0	1	2	3	Brain Fog
0	1	2	3	Memory loss-short/long term
0	1	2	3	Pain or swelling in joints
0	1	2	3	Stiff joints in morning
0	1	2	3	Muscle twitching
0	1	2	3	Unexplained fevers
0	1	2	3	Headaches/Migraines
0	1	2	3	Poor Concentration
0	1	2	3	Sore soles of feet in morning
Total:				

Cardiovascular System:

0	1	2	3	Shortness of breath w/ moderate exertion
0	1	2	3	Opens windows in closed room
0	1	2	3	Sigh frequency
0	1	2	3	Bruise easily
0	1	2	3	Ankles swell at end of day
0	1	2	3	Muscle cramps during exercise
0	1	2	3	Hands and feet go to sleep
0	1	2	3	Dull pain in chest, worse on exertion
Total:				

Vitamin Deficiencies:

0	1	2	3	Body jerks as falling asleep
0	1	2	3	Restless leg syndrome
0	1	2	3	Small bumps on back of arms
0	1	2	3	Heart races
0	1	2	3	Worrier/anxious
0	1	2	3	Nosebleeds
0	1	2	3	Bruise easily
0	1	2	3	Gums bleed easily
0	1	2	3	Depressed regularly
0	1	2	3	Numbness or tingling in body
0	1	2	3	Loss of muscle tone
Total:				

Please circle all that apply. Follow key below.
Key: 0=none symptom does not occur; 1=Yes, mild symptom, rarely occurs; 2=Moderate symptom, occurs weekly; 3=Severe symptom, occurs daily

Adrenal Glands:

0	1	2	3	Difficulty falling asleep
0	1	2	3	Slow starter in the morning
0	1	2	3	Become dizzy when standing suddenly
0	1	2	3	Difficulty holding chiropractic adjustments
0	1	2	3	Arthritis
0	1	2	3	Crave salty foods
0	1	2	3	Headache after exercise
0	1	2	3	Chronic low back pain
0	1	2	3	Clench or grind teeth
0	1	2	3	Perspire too easily
0	1	2	3	Hives
0	1	2	3	Brightness hurts eyes
0	1	2	3	Slow recovery from stress
Total:				

Kidney and Bladder:

0	1	2	3	Pain upon urination
0	1	2	3	Frequent bladder infections
0	1	2	3	Cloudy, bloody, or dark urine
0	1	2	3	Urine has strong odor
0	1	2	3	History of kidney stones
0	1	2	3	Dribbling urination
0	1	2	3	Pain in lower back
Total:				

Blood Sugar Problems:

0	1	2	3	Crave sweets
0	1	2	3	Awaken during night, hard to fall back asleep
0	1	2	3	Excessive appetite
0	1	2	3	Crave coffee or sugar in afternoon
0	1	2	3	Headache if meals are delayed
0	1	2	3	Get shaky or weak if hungry
0	1	2	3	Sleepy in afternoon
0	1	2	3	Fatigue relieved by eating
0	1	2	3	Afternoon headaches
0	1	2	3	Irritable before meal
Total:				

Thyroid Gland:

0	1	2	3	Difficulty losing weight
0	1	2	3	Loss of outer 1/3 eyebrows
0	1	2	3	Mentally Sluggish
0	1	2	3	Cold hands and feet
0	1	2	3	Hair loss
0	1	2	3	Easily fatigued
0	1	2	3	Seasonal sadness
0	1	2	3	Low body temperature
0	1	2	3	Sensitive to iodine
0	1	2	3	Fast pulse at rest
0	1	2	3	Nervousness
0	1	2	3	Sensitivity to cold
0	1	2	3	Intolerant to heat
0	1	2	3	Flush easily
0	1	2	3	Heart palpitations
Total:				

Diet:

Specific Food	**How Much**	**Per Day-Week-Month** *circle one*
Coffee	_____Cups	Day Week Month
Soft Drinks	_____Can(s)	Day Week Month
Diet Soda	_____Can(s)	Day Week Month
Candy	_____Time(s)	Day Week Month
Chocolate	_____ Time(s)	Day Week Month
Alcohol	_____Drink(s)	Day Week Month
Fast Food	_____Time(s)	Day Week Month
Milk/Cheese	_____Time(s)	Day Week Month
Fried Food	_____Time(s)	Day Week Month
Margarine/Tub Spreads	_____Time(s)	Day Week Month

Current Diet: *Give average examples of your daily diet:*

Breakfast:	Lunch:	Dinner:	Snacks:

How many meals do you eat per day?_____
Do you skip any meals?_____ If so, which one(s)?_____
How often do you eat out?_____

List some of your most common food items:

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

How serious are you about improving your health? *Circle one.*
Very Serious Serious Other_____

What are you willing to do to improve your health? *Circle one.*
Take supplements Exercise WHATEVER IT TAKES!