soMEday DECISIONS

Supporting your body's path to better health

Client Intake Form

Thank you for taking the time to complete this form. The more detail you provide, the better I can understand your health journey and what matters most to you. Please answer thoughtfully and honestly. There are no right or wrong answers — only your experiences.

PERSONAL INFORMATION

Full Name:

Email:

Date of Birth:

Emergency Contact (Name & Phone):

Address:

Occupation

Phone:

YOUR HEALTH STORY

What brings you in at this time?

When did you first begin noticing changes in your health, energy, or overall well-being?

What do you feel has most influenced how you feel today?

What approaches, programs, or treatments have you tried in the past?
What helped? What did not?

Health is often shaped by more than diet and lifestyle alone. Has anything significant occurred in your life that may still be influencing your physical or emotional well-being? (Examples: major life transitions, caregiving responsibilities, loss, diagnosis, career changes, or other meaningful events.)

CURRENT MEDICAL & HOLISTIC CARE

Are you currently under the care of a medical provider?

☐ Yes ☐ No

Are you currently working with a holistic or functional health practitioner?

☐ Yes ☐ No

If yes to either, please explain:

Please list any major illnesses, injuries, or surgeries (include approximate dates):

Have you had any organs removed or procedures that may impact how your body functions? (Examples: gallbladder, appendix, uterus, ovaries, thyroid, part of stomach or intestine, etc.)
If yes, please list with approximate dates:

Please list any current medications (name and reason):

Name of medication	Reason for taking	How long have you been taking?

Please use a separate sheet of paper if more space is needed.

Please list any nutritional supplements you are currently taking (brand if known):

Name of supplement	Reason for taking	How long have you been taking?

Please use a separate sheet of paper if more space is needed.

Family history of significant health conditions:

MOVEMENT & ENERGY

How would you describe your current activity level?

- [ ] Sedentary
- [ ] Lightly Active
- [ ] Moderately Active
- [ ] Very Active

If applicable, what types of movement or exercise do you engage in?

Are there any injuries or limitations that affect your activity level?

How would you describe your energy throughout the day?

- [ ] Strong in the morning
- [ ] Afternoon slump
- [ ] Wired at night
- [ ] Fluctuates
- [ ] Often fatigued

Based on energy, what is your best time of day? What is your lowest time of day?

Do you feel more often:

- [ ] Calm
- [ ] Wired
- [ ] Tired
- [ ] Foggy
- [ ] Anxious
- [ ] Variable

SLEEP, STRESS & RESTORATION

How would you describe your mood most days?

- ☐ Steady
- ☐ Irritable
- ☐ Low
- ☐ Anxious
- ☐ Overwhelmed
- ☐ Variable

How many hours of sleep do you typically get each night?

Do you fall asleep easily? Stay asleep? Wake rested?

What tends to keep you awake at night, if anything?

How would you describe your current stress level?

☐ Low ☐ Moderate ☐ High

What are the primary sources of stress in your life right now?

What do you typically do to unwind or decompress at the end of your day?

How much screen time do you spend:

During the day:

During the evening:

What types of devices do you use? (computer, gaming, cell phone, iwatch, etc)

FOOD & DAILY NOURISHMENT

What percentage of your meals are prepared at home versus eating out?

If you eat out regularly, where do you most often eat?

How much water do you drink daily?

Caffeine intake (type and amount per day):

Alcohol intake (type and frequency):

Do you skip meals? If yes, which meals and how often?

How often do you have a bowel movement?

- ☐ Daily
- ☐ Every other day
- ☐ Less than 3x per week
- ☐ Multiple times daily
- ☐ Irregular

Understanding your bowel movements can reveal important insights into your digestive health. Is there anything else you'd like me to know?

Do you experience strong food cravings?

☐ Yes ☐ No

If yes, what foods do you crave most often?

When do cravings typically occur? (time of day, stress, after meals, etc.)

Are there any foods you intentionally avoid?

☐ Yes ☐ No

If yes, please list the foods and explain why you avoid them. (Examples: past allergy or intolerance testing, personal preference, ethical reasons, advice from a provider, etc.)

Are there any foods your body does not tolerate well, even if you do eat them? (Examples: digestive upset, headaches, skin changes, fatigue, mood shifts, etc.)

If yes, please describe the food and the reaction you notice:

ENVIRONMENTAL & LIFESTYLE FACTORS

Who lives in your home? (spouse/partner, children, parents, roommates, etc.)

Do you have pets? If yes, please list (ie cats, dogs, reptiles, etc).

Who prepares most of the meals in your household?

Do you feel supported in making dietary or lifestyle changes?

Describe your typical daily schedule
(include shift work if applicable):

Are there any home, work, or environmental exposures you believe may impact your health?
(chemicals, mold, travel, air quality, cleaning products, etc.)

READINESS & REFLECTION

On a scale of 1–10, how motivated do you feel to take the next steps in your health journey?
(1 = not at this time, 10 = highly motivated) ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

What might interfere with your ability to follow through on recommendations?

If we were sitting here six months from now and things were better, what would be different?

Is there anything else about your health, experiences, or daily life that you would like me to know?