EpicLuv

Intake Questionnaire

Personal Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Marital status

Occupation

Hours per week

Referred by

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Have you ever taken antibiotics? ○ Yes ○ No

If so, when?

Have you ever taken birth control? ○ Yes ○ No

If so, when?

Have you ever been on hormone replacement therapy? ○ Yes ○ No

If so, when?

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

List your current health concerns in order of importance

Health Concerns

Do you experience digestive difficulties?

(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement? ○ Yes ○ No

Are your bowels loose? ○ Yes ○ No

Do you take laxatives? ○ Yes ○ No

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Do you avoid these foods? ○ Yes ○ No

Diet

How much water do you drink daily?

Do you consume coffee? ○ Yes ○ No

If so, how much, how often?

Do you consume tea? ○ Yes ○ No

If so, how much, how often?

Do you consume alcohol? ○ Yes ○ No

If so, how much, how often?

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Do you experience any symptoms after meals?

Describe your relationship with food
Please be very specific

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? You wake frequently during the night?

Do you wake feeling rested? ○ Yes ○ No

How often do you exercise?

What types of exercise do you do?

What do you do to have fun?

How do you express your creativity?

Do you have any pets? ○ Yes ○ No

What level of stress are you currently experiencing?

List your main stressors

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

How many hours per day do you use a computer?

How many hours per day do you use a cell phone?

How many hours per day do you use watch TV?

Chemicals

Where did you grow up?
City or country?

○ City ○ Country

What type of environment do you/ have you worked in?

How many cigarettes do you smoke per day?

For how many years? If you quit, how long ago?

Do you or have you used recreational drugs?

○ Yes ○ No

Have you had any dental work done?
Do you have fillings (metal), root canals, crowns, etc?

Have you ever had shots/vaccinations?
List all that apply (including flu shots)

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 = Lowest, 10 = Highest