GREEN SHADE WELLNESS

HEALTH COACH • COLON HYDROTHERAPY
AROMATHERAPY • CHINESE TRADITIONAL
HERBALOGY COOKING CLASSES FOR HEALING FOODS

INTAKE FORM

Please write or print clearly.

Total Score: _____
For Office Use Only

Name: _____ DOB: _____

Gender: ❑ Male ❑ Female ❑ Other Height: _____ Weight: _____

Address: _____

Town: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Mobile Phone: ( ) _____

Occupation: _____ Hours/week working? _____

Work Phone: ( ) _____ eMail: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: ( ) _____ Town: _____

Primary Care Physician (PCP): _____

PCP Practice Name: _____

PCP Town: _____ PCP Phone: ( ) _____

What is your primary goal from working with Green Shade Wellness? _____

_____

_____

All information shall be kept confidential, unless written permission has been granted to pass information on to any other health facility or 3rd party.

Our intake form is a little more in-depth than traditional health related questions. A more detailed overview of your background, history, and day to day activities provides the best picture to understand you better as an individual and what factors may play a part in improving your overall health. Please try to answer the following questions to the best of your ability, and add any relevant details.

Your answers are confidential, judgement free, and your honesty can help us best serve you.
If you are not comfortable answering anything, please write DA or Decline to Answer, and do not leave any blank spaces.

Your Health

Do you have any current Health Concerns: _____

_____

Do you have any current Health Conditions: _____

_____

Are you taking any current medications: _____

_____

Are you currently practicing a specialized diet: _____

_____

Have you had any recent serious injuries: _____

_____

How much do you weigh? _____ lbs 6 Months ago? _____ lbs A Year ago? _____ lbs

If you could change your weight, how much would you want to weigh? _____ lbs

Do you get an annual physical? ❑ Yes ❑ No ❑ Not annually, but every few years

Do you know how your cholesterol level is? ❑ Low ❑ Normal ❑ High ❑ Unknown
Do you know how your blood pressure is? ❑ Low ❑ Normal ❑ High ❑ Unknown

How would you rate your overall stress level?	(Low)	0	1	2	3	4	5	6	7	8	9	10	(High)
Stress level at work?	(Low)	0	1	2	3	4	5	6	7	8	9	10	(High)
Stress level around family?	(Low)	0	1	2	3	4	5	6	7	8	9	10	(High)
If in a relationship, stress level with your partner?	(Low)	0	1	2	3	4	5	6	7	8	9	10	(High)

Do you use any techniques or have hobbies to relieve stress? _____

_____

Do you enjoy your job? ❑ No, Not at all ❑ It's OK ❑ Most of the time ❑ Yes, Very Much ❑ N/A

Do you work with any chemicals or things which might affect your health? _____

_____

Your Health (continued)

Do you have children? ❑ Yes ❑ No If yes, ages? _____

Do you have pets? ❑ Yes ❑ No If yes, types? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how often? _____

Do you use any recreational drugs? ❑ Yes ❑ No
If yes, types and frequency? _____

Do you smoke cigarettes? ❑ Yes ❑ No If yes, how often? _____

Do you eat fast food? ❑ Yes ❑ No If yes, how often? _____

Do you take vacations? ❑ Yes ❑ No If yes, how often? _____

Do you crave sugary foods? ❑ Yes ❑ No If yes, how often? _____

Do you take vitamins? ❑ Yes ❑ No If yes, types? _____

Do you take supplements? ❑ Yes ❑ No If yes, types? _____

Do you exercise? ❑ Yes ❑ No If yes, how often? _____

What role does exercise play in your life? _____

_____

_____

How would you rate your quality of sleep? (Bad) 0 1 2 3 4 5 6 7 8 9 10 (Great)

How would you describe your sleeping patterns? _____

_____

How many ounces of water do you drink daily? _____ oz What types of water? ❑ Bottled ❑ Well

❑ City ❑ Filtered ❑ Spring ❑ Distilled ❑ Reverse Osmosis ❑ Other _____

Averagely, how many hours a week do you use a computer? _____

Averagely, how many hours a week do you watch TV? _____

Averagely, how many hours a week do you use your mobile phone for talking? _____

Averagely, how many hours a week do you use your mobile phone texting/apps? _____

Averagely, how many hours a week do you spend driving? _____

Averagely, how many hours a week do you spend outside? _____

Your History

Where were you born? _____

Where did you primarily grow up? _____

What do you consider your ancestry? _____

Mother's Background

Is your mother still living? ❑ Yes ❑ No How old is she or was she at the time of her passing? _____

What was your personal opinion of the overall health of your mother while you were growing up? (circle one)

(Unknown) 0 1 2 3 4 5 6 7 8 9 10 (Great)

Did your mother have any serious illnesses or conditions? _____

_____

_____

Father's Background

Is your father still living? ❑ Yes ❑ No How old is he or was he at the time of his passing? _____

What was your personal opinion of the overall health of your father while you were growing up? (circle one)

(Unknown) 0 1 2 3 4 5 6 7 8 9 10 (Great)

Did your father have any serious illnesses or conditions? _____

_____

_____

Are there any family health issues that are a concern to you? _____

_____

_____

_____

_____

Can you think of anything about your past which may be affecting your health today? _____

_____

_____

Dietary

Please list common items you had as a child - - -

For Breakfast: _____

_____

For Lunch: _____

_____

For Dinner: _____

_____

For Snacks: _____

_____

Beverages: _____

_____

What percentage of your current food intake is home cooked? _____

What percentage of your current food intake is processed food? _____

List some common beverages you drink often: _____

_____

List some of your favorite foods: _____

_____

Do you personally cook? ❑ Yes, always ❑ Sometimes ❑ No, I never do

Do you eat organic foods? ❑ Yes ❑ Sometimes ❑ No

Do you skip meals? ❑ Yes, I usually skip _____ ❑ Sometimes, I skip _____ ❑ No

What is the biggest thing you would like to change about your diet? _____

_____

_____

_____

Do you feel you have friends/family who would support a change in your lifestyle? ❑ Yes ❑ No

Please circle your answer: (0)=Never (1)=Rarely (2)=1-2 times a week (3)=often(3-4 a week) (4)=always/daily

TCM Liver-Blood Disharmony

Please Circle One	Do you have…	Please add details here…
0 1 2 3 4	Vision Spots?	
0 1 2 3 4	Dizziness?	
0 1 2 3 4	Eye Pain?	
0 1 2 3 4	Body Pains?	
0 1 2 3 4	Stiffness or swelling?	
0 1 2 3 4	Headaches?	
0 1 2 3 4	Uncontrollable anger?	
0 1 2 3 4	Depression?	
0 1 2 3 4	Mood fluctuations?	
0 1 2 3 4	Indigestion from fatty foods?	
0 1 2 3 4	Life frustrations?	
0 1 2 3 4	Nausea or vomiting?	
0 1 2 3 4	Teeth grinding?	
0 1 2 3 4	Itchy Skin?	
0 1 2 3 4	Insomnia?	
0 1 2 3 4	Ringing or noises in your ear?	
	Bowl Movements	Do you have get constipation? **0 1 2 3 4** Do you get diarrhea? **0 1 2 3 4** Do you have a daily BM? Consistency, color, or odor concerns?
	For Females	Do you have a regular period? How long does it usually last? Bright or dark red? Blood clots?