Huckleberry Healing

Intake Form

Please fill out these forms honestly and as thorough as possible. Accurate information will help me understand your overall health, nutrition, and wellbeing, so I can assist you in achieving your health goals!

CONTACT INFO

Name _____ **Date** _____

Address _____ **City** _____ **State/Zip** _____

Best number to reach you _____ **Email**_____

Best time to contact you _____ **Prefer Email or Phone? Email** ☐ **Phone** ☐

Emergency Contact _____ **Phone** _____

PERSONAL INFORMATION

Birthdate _____ **Gender** _____ **Height** _____ **Weight** _____

Ethnicity (Optional) _____ **Marital Status** _____

Children? _____ **If yes, how many?** _____ **Occupation** _____

Average hours in a work week? _____ **Are you satisfied with your career?** _____

Is your job stressful? Yes ☐ **No** ☐ **Sometimes** ■

On a scale from1-10 (10 being very stressed), rate your overall stress level _____

What are some major stressors in your life? _____

On a scale from 1-10, (10 being excellent) rate your quality of sleep _____

Average bedtime _____ **Average waking time** _____ **Average hours of sleep per night?** _____

List any regular physical activities, including frequency and duration _____

_____

Hours a day you spend: Driving _____ **Watching TV** _____ **On phone** _____

On computer _____ **Exercising** _____ **Relaxing** _____

Did you/do you smoke? _____ If yes, what? _____ How Often? _____

Do you use recreational drugs? _____ If yes, what? _____ How often? _____

NUTRITION AND DIETARY HABITS

What time do you usually eat: Breakfast _____ Lunch _____ Dinner _____

How many meals do you typically eat a day? _____ Do you snack? _____ If so, when? _____

_____

How many times a week do you:

Eat out at restaurants? _____ Eat breakfast? _____ Cook meals at home? _____

Eat alone? _____ Eat Dessert? _____ Grocery Shop? _____

What are some of your favorite foods? _____

_____

Do you avoid certain foods? Any food allergies? Explain: _____

_____

_____

What are your favorite restaurants? _____

_____

Where do you grocery shop? _____

_____

Do you generally purchase organic or conventional foods? _____

_____

How many glasses of water do you drink a day? _____ Is it filtered/purified? _____

What fats/oils do you usually cook with? _____

_____

Which of the following foods or beverages do you consume regularly?

Coffee? ☐ How many cups? _____ Gluten? ☐ How much? _____

Soda? ☐ How many cups? _____ Dairy? ☐ How much? _____

Diet soda? ☐ How many cups? _____ Fast food? ☐ How much? _____

Refined sugar? ☐ How much? _____ Alcohol? ☐ How many cups? _____

Please indicate how often you consume:

Meat	☐ Daily	☐ 3-5 times/week	☐ 1 time/week or less
Eggs	☐ Daily	☐ 3-5 times/week	☐ 1 time/week or less
Vegetables	☐ Daily	☐ 3-5 times/week	☐ 1 time/week or less
Fruit	☐ Daily	☐ 3-5 times/week	☐ 1 time/week or less
Grains	☐ Daily	☐ 3-5 times/week	☐ 1 time/week or less
Dairy	☐ Daily	☐ 3-5 times/week	☐ 1 time/week or less

Have you ever tried or are you currently on a popular diet? Is so, explain? _____

_____

How did it/does it feel? _____

Are you pleased with your current diet? Yes ☐ No ☐

Would you like to change anything? Explain: _____

_____

Eating patterns: (check all that apply)

Overeat ☐	Fast eater ☐	Forget to eat ☐
Under eat ☐	Healthy choices ☐	Eat in the car ☐
Sugar cravings ☐	Poor choices ☐	Eat while working ☐
Emotional eater ☐	Hungry constantly ☐	Eat out of boredom ☐

Do you experience any symptoms after eating meals? Explain:_____

_____

Do you experience symptoms if you miss meals? Explain: _____

_____

What influences your food choices? (Check all that apply)

Taste ☐ Nutrition ☐ Family/Friends ☐ Convenience ☐ Ethnicity ☐ Emotions ☐

MEDICAL HISTORY

What is the most you have ever weighed? _____ When? _____

What is the least you have ever weighed? _____ When? _____

Have you had any recent changes in your weight that you are concerned about? Explain:

_____

How would you describe your general state of health?

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** **Comments? _____**

What is your blood type? _____

How often do you have a bowel movement?

☐ **3 +/day** ☐ **2/day** ☐ **1/day** ☐ **3-4 times/week** ☐ **1-2 times/week or less**

Does it hurt to have a bowel movement? Yes ☐ **Sometimes** ☐ **No** ☐

If yes or sometimes, explain: _____

Do you ever have loose bowel movements? Yes ☐ **Sometimes** ☐ **No** ☐

If yes or sometimes, explain: _____

PAST MEDICAL/SURGICAL INFORMATION

For the following chart, please indicate whether you or a relative have been diagnosed with any of the following illnesses or diseases. If there are multiple types, please specify which one you or a relative has/has had. Please be specific! Use back of the page if needed.

ILLNESS: DISEASE	WHO & AGE DIAGNOSED	DESCRIBE:SPECIFY
EX: Autoimmune Condition	Me: Diagnosed at age 5	Celiac Disease
Alcoholism		
Allergies (specify type)		
Anemia		
Anxiety:Panic Attacks		
Arthritis		
Asthma		
Autoimmune condition		
Bronchitis		
Cancer		
Celiac Disease		
Chronic Fatigue Syndrome		
Crohn's Disease		

Ulcerative Colitis		
Diabetes (Specify type)		
ILLNESS: DISEASE	**WHO & AGE DIAGNOSED**	**DESCRIBE:SPECIFY**
Dermatitis		
Eczema		
Emphysema		
Epilepsy		
Eye Disease (Specify)		
Fibromyalagia		
Food Allergies/Intolerances		
Fungal Infection (Specify)		
Gallbladder Disease		
Gout		
Heart Attack/Angina		
Heartburn		
Heart Disease (Specify)		
Hepatitis		
High blood fats (Specify)		
High blood pressure		
Hypoglycemia		
Intestinal Disease (Specify)		
Inflammatory Bowel Disease		
Irritable Bowel Syndrome		
Kidney Disease		
Lung Disease		
Liver Disease		
Mononucleosis		
Osteoporosis		
PMS (Specify severity)		
Polycystic Ovarian Syndrome		
Pneumonia		
Prostate Problems		
Psychiatric Conditions		
Seizures		
Shingles		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid Disease (specify)		
Urinary Tract Infection		
Surgeries/Hospitalizations (Specify)		

Injuries		**Medication Taken:**
Diagnostic Studies (X-rays, bone scans, etc.)		

Please list any other illnesses or conditions that you or your family is currently dealing with/ has dealt with: _____

_____

_____

MEDICATION, ANTIBIOTIC, SUPPLEMENT PAST AND CURRENT INTAKE

Please indicate antibiotics, supplements, or medication you are currently taking or have taken in the past. Please be as specific as possible. Include your infancy/childhood.

Medication/Supplement/ Antibiotic	**Dose (if known)**	**Length of Use (include if current)**	**Taken For?**	**Issue Resolved?**
EX: Metabolic Synergy (Designs Health	6 capsules:day	6 months-present	hypoglycemia	Improving!

Are you allergic to any medication? _____ If yes, specify: _____

FEMALES ONLY

Are you pre-menopausal or menopausal? _____

Are you taking hormone replacement therapy? _____ List symptoms/concerns _____

Date of last menstrual cycle? _____ Are your menstrual cycles irregular? _____

If yes, please explain: _____

Number of pregnancies _____ Age of your child/children _____

Are you currently pregnant? _____ If so, when is your due date? _____

Are you currently trying to conceive? _____ If so, for how long? _____

HEALTH GOALS AND OBJECTIVES

The primary reason/reasons you are seeking nutritional assistance: _____

_____

_____

Food and nutrition related goals: _____

_____

_____

Overall health goals: _____

_____

_____

Regarding your food and lifestyle choices, are there any changes you think you should make? If yes, please explain: _____

_____

_____

_____

Are there any obstacles or challenges you experience while making these changes? Explain:

_____

_____

_____

On a scale from 1-5, please rate your readiness/willingness to do the following:

TO IMPROVE YOUR HEALTH, HOW WILLING ARE YOU TO:	1	2	3	4	5
Significantly change your diet					
Take nutritional supplements/herbal medicines each day					
Keep a food journal of everything you eat each day					
Modify your work habits, exercise habits, and sleep habits					
Partake in relaxation techniques/exercises					
Have periodic lab tests to record improvements/assess progress					
Reduce alcohol or drug intake					
Reduce coffee or soda intake					
Increase daily water intake					

Is there anything else you would like to add that was not covered in this form? _____

_____

_____

_____

Do you have any questions for me? _____

_____

_____

_____

SIGNATURE LINE

By signing this form, I agree that all of the above statements are true to the best of my knowledge. If significant changes occur, I agree to notify Huckleberry Healing as soon as possible. I understand and agree that confidential information of my medical, nutrition, and health history will be maintained by Huckleberry Healing LLC. I understand it will not be released to any individual unless I give written permission to do so or when it's required by law.

Signature _____ Date _____

Kelsey Huckle
Huckleberry Healing LLC
Montrose, CO 81401
hucklberryhealingllc@gmail.com
(970) 275-6797