Adult Client Intake Questionnaire

Basic Information

Name: ______________________ Preferred email address: ____________________________

Mailing Address: ____

Preferred phone number: __________________________

How do you prefer to be contacted for check-ins?

Email Text Phone Call Instagram DM

How did you hear about my services? ____

Birthdate: ____________________ Age: ______ Weight: _______ Height: ________

Occupation: ____

Previous occupations: ____

Health Profile

Past experiences with practitioners? Mostly interested if you had bad experiences.

Circle any other practitioners you're **currently** working with:

Chiropractic - Naturopathic - Counselor - Homeopath - Massage - Reflexologist

Personal trainer - Colon Hydrotherapist - Other: ___________________________

List one to five health goals you would like to attain for yourself, in order of priority:

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I haven’t felt well since: ____

What do you suspect is the reason for your current condition(s)?

Please include dates where possible on the rest of this page’s questions:

Do you have a recent medical diagnosis?

Have you had any surgeries?

Past Conditions or health information you’d like us to know - include childhood illnesses and vaccinations - both childhood and adult:

Immediate Family Health Concerns:

Mom’s Side of Family Health History:

Dad’s Side:

Do you have any physical traumas or accidents?

ROOTS & FRUIT WELLNESS · GET WELL. BE WELL. STAY WELL.

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Stress Profile

What is your relationship to stress like?

What stressors are currently in your life?

What past stressors impacted you in the past but aren't currently happening?

How do you manage or relieve stress?

What are your hobbies?

Medicinal Profile

List any medications you have taken or are currently taking

Medication: Date Started: Reason:

List any supplements you are currently taking

Supplement: Amount: Reason:

Lifestyle Profile

On a scale of 1 to 10, rate the following:

Your current energy levels ______ Your current bowel movements ______
Your current sleep quality ______ Your current overall quality of life ________

Please describe your sleep schedule (include time of bed, waking, and any frequent or recurring wakeups or problems in the night)

How much water (including *herbal* tea) do you drink per day? ____________________

Do you drink coffee? How many cups per day? __________

How often do you have a bowel movement and what do they look and smell like?

Circle any of the following you consume:

Alcohol - Tobacco - Raw fish - Black Tea - Green Tea - Pop

Concentrated Fruit Juice - Fresh pressed juice - Artificial Sweeteners

Milk - Cream - Margarine - Canola Oil - Marijuana - Recreational Drugs

Circle any of the following you use and indicate how much beside each circled one:

Cell Phone - Laptop - Desktop computer - Smart Home Devices

Electric Blanket - Antiperspirant - Perfume/Hairspray - Pesticides on Lawn/Garden

Do you smoke? Yes No Have you in the past? Yes No

What do you do for exercise, and how often?

Do you sweat when you exercise? Yes No

Do you have any tattoos? If so, how many? Yes _____ No

How old is your home? Remodeling/construction? Carpets? Paint?

Do you know your blood type? ___________________

Do you bruise easily or get canker sores?

List 5 foods that you love, how often you eat them, and what you like about them.

Please circle any equipment that you have in your kitchen:

Water filtration system - High speed blender - Food processor - Juicer
Air fryer - Microwave - Toaster Oven - Immersion Blender - Dehydrator

Do you have any dental fillings? Please expand if so (what material, what teeth?)

Have you ever received a root canal? What teeth? Crowns or other metals (retainer, braces, etc)?

Women Only Section

Check any of the following that apply to you:

___ I do not have regular cycle
___ I am peri menopausal
___ I have a regular cycle
___ I get PMS symptoms before my period
___ I have bad cramping with my period
___ I get recurring UTIs
___ I have taken birth control pills in the past
___ I am currently taking birth control pills
___ I have done hormone replacement therapy in the past
___ I am currently doing hormone replacement therapy
___ I am aware of the four phases of my cycle
___ I am frustrated by my hormones
___ I want to have a happier cycle
___ I have hormonal acne
___ I bleed heavily during my period
___ My period is longer than I'd like
___ My period used to be regular and recently changed
___ I am menopausal

Have you ever been pregnant? Yes No

Please describe any pregnancies, births, and related procedures you have had:

For all clients - what obstacles do you foresee coming up as we work together on a plan for your health?

If you have any concerns about this process, questions about nutrition or other information you think would be helpful to know, please use this box to address it:

Please complete the 3 day Food, Mood, Poop journal on the chart provided.

This information is provided for a holistic nutritional assessment. I understand that the information I am seeking is of a nutritional nature and not a medical diagnosis.

Signature: ______________________________ Date: ____________________

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Name: ______________________________ **Date:** ______________________________

Time	Food	Mood	Poop	Drinks & Supplements

Exercise, sleep & other notes:

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Name: ____________________________________ **Date:** ____________________________

Time	Food	Mood	Poop	Drinks & Supplements

Exercise, sleep & other notes:

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Name: ______________________________ **Date:** ______________________________

Time	Food	Mood	Poop	Drinks & Supplements

Exercise, sleep & other notes: