Intake & Consent Form

Name			
Date of Birth		**Sex at Birth:**	
Address			
Home Phone		**Cell Phone**	
Occupation		**Email Address**	
Primary Care Physician			
How did you hear about us?			

Medication/Supplement	**Dose**	**Frequency**	**Reason**	**Other**

Have you been diagnosed with any physical, mental, or emotional medical conditions?

Diagnosis	**Date of Diagnosis**	**Current Treatment Approach**

Exercise

How often do you exercise (check one)?

___ Rarely ____ 1-2 days per week ____ 3-5 days per week ____ 6-7 days per week

How long is your exercise activity per session? ____ None ____ <30 min ____ 30-60 min ____1 hr ___ >1hr

What Type of Exercise do you do regularly? (select all that apply)

____ Walking _____Jogging/Running _____Weight Training _____ Yoga/Pilates Other:_____

Do you enjoy exercise? Explain: _____

What time of day do you usually exercise? _____

Sleep

How many hours of sleep do you get per night?

_____ <4 hours _____ 4-5 hours _____ 6-8 hours _____ >8 hours

Do you feel rested when you wake up? _____ Yes _____ No

How do you feel mostly throughout the day? ____ Tired & Fatigued _____ Energetic & Alert _____ In-Between

Stress

How would you describe your general stress level? _____ High Stress _____ Moderate _____ Low Stress

What types of things stress you out the most? _____

_____

How do you usually cope with stress? _____

_____

Physical Symptoms

- ☐ Acid Reflux/Heartburn/GERD
- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis/Joint pain
- ☐ Asthma
- ☐ Belching
- ☐ Bloating
- ☐ Bruising
- ☐ Cancer
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Dry skin
- ☐ Ear problems
- ☐ Eczema
- ☐ Family history of disease: _____
- ☐ Fatigue
- ☐ Fibromyalgia/Muscle Pain
- ☐ Flatulence
- ☐ Frequent cold/flu
- ☐ Frequent urination
- ☐ Headache/Migraines
- ☐ Heart problems
- ☐ Hemorrhoids
- ☐ High/Low blood pressure (specify)
- ☐ HIV/AIDS
- ☐ Hives/Itching
- ☐ Infertility
- ☐ Irregular periods
- ☐ Low blood sugar
- ☐ Metabolic syndrome
- ☐ Mood changes/Irritability
- ☐ Muscle cramps
- ☐ Neck pain/Back pain
- ☐ Painful periods
- ☐ PMS
- ☐ Sciatica
- ☐ Sinus/Drainage problems
- ☐ Sleep problems
- ☐ Swelling
- ☐ Tingling fingers/toes
- ☐ Tremors
- ☐ Vertigo
- ☐ Vision problems
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:_____

Eating Assessment Scale

(Evelyn Tribole / New Harbinger Publications)

Physical Symptoms	Social Symptoms	Psychological Symptoms	Behavioral Symptoms
☐ Weight gain. ☐ Blunted metabolism. ☐ Excessive cravings for carbs. ☐ Blood sugar swings. ☐ Disconnected from hunger cues. ☐ Disconnected from satiety cues. ☐ Chronically tired, even when sleeping well. ☐ Hair loss (more than usual). ☐ If female: missed or inconsistent menses. ☐ Physical numbness ☐ Other:	☐ I eat differently when others are present. ☐ I compare my food to what others are eating, in quantity and type of foods. ☐ I worry about what people think about my eating. ☐ I worry about what people think about my body. ☐ I try to eat the same type and quantity of food that others are eating. ☐ I cancel social events because of the food or meals served. ☐ I avoid eating in social situations. ☐ My behavior and beliefs about my eating and body have interfered with relationships. ☐ Other:	☐ I worry about my eating. ☐ I have strict rules about eating. ☐ I count calories, carbs, or other factors about food. ☐ I think of foods as “good” or “bad.” ☐ I feel guilty if I eat a “bad” food. ☐ I have mood swings. ☐ I am afraid of feeling hungry. ☐ I am afraid of feeling too full. ☐ I don’t trust my body. ☐ I am afraid that if I start eating “forbidden” foods, I won’t stop eating. ☐ I fantasize about food. ☐ I am preoccupied by thoughts about what I eat and don’t eat. ☐ Other:	☐ If I break a food rule, I eat even more of it. ☐ If I eat too much, I make up for it by skipping a meal or eating less food at the next meal, even if I am hungry. ☐ I eat more food when I’m stressed. ☐ I exercise only to burn calories or lose weight. ☐ I talk a lot about dieting, weight, and food. ☐ When I’m on vacation, I ignore my food rules and eat more than I need, no matter how full I feel. ☐ I engage in binge eating. ☐ I avoid physical intimacy. ☐ Other:

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Alexandra Tarr will not be held liable for failure to diagnose or treat an illness, nor will she be liable for failure to prevent future illness. Additionally, you promise to give Alexandra a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

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Client's Signature: _____ Date: _____