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New Client Form:

Date: _____ Medical/Allergy Allerts: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Home Phone: _____ Work Phone/Cell: _____

Occupation: _____ Employer: _____

Medical Doctor: _____ Date of last visit: _____

Reason for last doctor's apt. _____

Height: _____ Weight: _____ Do you smoke? □Yes □ No

Referred by: _____

What is the primary reason for your visit?

How would you describe your health?

Describe your diet and eating habits.

Briefly state your relationship to the following, including any issues, concerns and successes.

Cooking: _____

Eating: _____

Sleeping: _____

Social Life: _____

Creative Projects: _____

Exercise & Movement: _____

Spiritual Practices: _____

Family: _____

Career: _____

List all medications you currently take and for what condition. (both prescription & OTC)

List all supplements you currently take. (vitamins, herbs, etc.)

Check any conditions you have or have had in the past.

☐ HIV/AIDs	☐ Cancer	☐ Hepatitis	☐ Meningitis	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ High blood pressure	☐ Mental condition	☐ Rheumatic fever
☐ Allergies	☐ Diabetes	☐ Multiple Sclerosis	☐ Ulcers	☐ Antibiotic use
☐ Epilepsy	☐ Mumps	☐ Stroke	☐ Vascular disease	☐ Asthma
☐ Glaucoma	☐ Kidney Disease	☐ Thyroid disorders	☐ Venereal disease	☐ Heart Disease
☐ Pneumonia	☐ Depression	☐ Other(s) _____		

List any illnesses requiring surgery incl. dental (date and doctor)

Any other serious injury, broken bones, scars, etc (list age at the time)

List major emotional events that have occurred in your life (rites of passage, marriage, divorce, births, deaths, etc.)

Date of last:

Physical: _____

HIV Test: _____

Pap Smear: _____ Have you ever had an abnormal PAP? ☐ Yes ☐ No

Blood Test: _____

Cholesterol Test: _____ Total Cholesterol: _____

Prostate Test: _____

Mammogram: _____

Metabolic Assessment Form

Name: _____ Age: _____ Sex:_____ Date: _____

PART I

Please list the 5 major health concern in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II **Please check mark the appropriate number "0 – 3" on all questions below.**
0 as the least/never to 3 as the most/always.

Category I	0	1	2	3
Feeling that bowels do not empty completely	☐	☐	☐	☐
Lower abdominal pain relief by passing stool or gas	☐	☐	☐	☐
Alternating constipation and diarrhea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Hard dry or small stool	☐	☐	☐	☐
Coated tongue of "fuzzy" debris on tongue	☐	☐	☐	☐
Pass large amount of foul smelling gas	☐	☐	☐	☐
More than 3 bowel movements daily	☐	☐	☐	☐
Do you use laxative frequently	☐	☐	☐	☐

Category II	0	1	2	3
Excessive belching burping or bloating	☐	☐	☐	☐
Gas immediately following a meal	☐	☐	☐	☐
Offensive breath	☐	☐	☐	☐
Difficult bowel movements	☐	☐	☐	☐
Sense of fullness during and after meals	☐	☐	☐	☐

Category V	0	1	2	3
Greasy or high fat foods cause distress	☐	☐	☐	☐
Large bowel gas and or bloating several hours after eating	☐	☐	☐	☐
Bitter metallic taste in mouth, especially in the morning	☐	☐	☐	☐
Unexplained itchy skin	☐	☐	☐	☐
Yellowish cast to eyes	☐	☐	☐	☐
Stool color alternates for clay colored to normal brown	☐	☐	☐	☐
Reddened skin, especially palms	☐	☐	☐	☐
Dry or flaky skin and/or hair	☐	☐	☐	☐
History of gall bladder attacks or stones	☐	☐	☐	☐
Have you had your gallbladder removed	**Yes**	☐	**No**	☐

Category VI	0	1	2	3
Crave sweets during the day	☐	☐	☐	☐
Irritable if meals are missed	☐	☐	☐	☐
Depend on coffee to keep yourself going or started	☐	☐	☐	☐
Get lightheaded and if meals are missed	☐	☐	☐	☐
Eating relieves fatigue	☐	☐	☐	☐
Feel shaky, jittery, tremors	☐	☐	☐	☐

Difficulty digesting fruits and vegetables; undigested foods found in stools	☐	☐	☐	☐

Category III

	0	1	2	3
Stomach pain, burning or aching 1-4 hours after eating	☐	☐	☐	☐
Do you frequently use antacids	☐	☐	☐	☐
Feeling hungry an hour or two after eating	☐	☐	☐	☐
Heartburn when lying down or bending forward	☐	☐	☐	☐
Temporary relief from antacids, food, milk, carbonated beverages	☐	☐	☐	☐
Digestive problems subside with rest and relaxation	☐	☐	☐	☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	☐	☐	☐	☐

Category IV

	0	1	2	3
Roughage and fiber cause constipation	☐	☐	☐	☐
Indigestion and fullnessn lasts 2-4 hours after eating	☐	☐	☐	☐
Pain, tenderness, soreness on left side under rib cage bloated	☐	☐	☐	☐
Excessive passage of gas	☐	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐	☐
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increase thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐
Agitated, easily upset, nervous	☐	☐	☐	☐
Poor memory, forgetful	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐

Category VII

	0	1	2	3
Fatigue after meals	☐	☐	☐	☐
Crave sweets during the day	☐	☐	☐	☐
Eating sweets does not relieve cravings for sugar	☐	☐	☐	☐
Must have sweets after meals	☐	☐	☐	☐
Waist girth is equal or larger than hip girth	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category VIII

	0	1	2	3
Cannot stay asleep	☐	☐	☐	☐
Crave salt	☐	☐	☐	☐
Slow starter in the morning	☐	☐	☐	☐
Afternoon fatigue	☐	☐	☐	☐
Dizziness when standing up quickly	☐	☐	☐	☐
Afternoon headaches	☐	☐	☐	☐
Headaches with exertion or stress	☐	☐	☐	☐
Weak nails	☐	☐	☐	☐