Tao Holistics

New Client Intake Form

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the practitioner during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Client Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Referred by

Statistics

Age

Height (in inches)

Blood Type

Current Weight

Ideal Weight

Weight One Year Ago

Birth Weight (if known)

Birth Order (please list ages of biological siblings)

Sibling	Current Age

Family/Living Situation

Children

Occupation

Exercise/Recreation

History

Have you lived or traveled outside of the United States? If so, when and where?

Have you or your family recently experienced any major life changes? If so, please comment.

Have you experienced any major losses in life? If so, please comment.

How much time have you had to take off from work or school in the last year?

- [ ] 0-2 days
- [ ] 3-14 days
- [ ] More than 15 days

Health Concerns

What are your main health concerns? (Describe in detail, including the severity of the symptoms).

Have any other family members had similar problems (please describe)?

When did you first experience these concerns?

How have you dealt with these concerns in the past?
Doctors, Self-Care, Other

Have you experienced any success with these approaches?

What other health practitioners are you currently seeing? List name, specialty and phone # below.

Please list the date and description of any surgical procedures you have had (including breast reduction or augmentation).

Surgical Procedure	Date	Description

How often did you take antibiotics in infancy/childhood?

How often have you taken antibiotics as a teen?

How often have you taken antibiotics as an adult?

List any medicine you are currently taking.

Medicine Name	Dosage	Frequency / Route	Duration	Comments

List all vitamins, minerals, herbs and nutritional supplements you are now taking.

Name	Dosage	Frequency / Route	Duration	Comments

Nutritional Status

Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and the symptom:

Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

Are there foods that you crave? If so please explain:

Describe your diet at the onset of your health concerns:

Do you have any known food allergies or sensitivities?

Which of the following foods do you consume regularly?

- ☐ soda
- ☐ diet soda
- ☐ refined sugar
- ☐ alcohol
- ☐ fast food
- ☐ gluten (wheat, rye, barley)
- ☐ dairy (milk, cheese, yogurt)
- ☐ coffee

Are you currently on a special diet?

- ☐ Autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ other (please describe below)
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free

If you checked "Other" from the question above, please describe in more detail here.

What percentage of your meals are home-cooked? Please describe.

Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

Bowel Movement Frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

Bowel Movement Consistency

- ☐ soft & well formed
- ☐ often float
- ☐ difficult to pass
- ☐ diarrhea
- ☐ thin, long or narrow
- ☐ small and hard
- ☐ loose but not watery
- ☐ alternating between hard and loose

Bowel Movement Color

- ☐ medium brown
- ☐ very dark or black
- ☐ greenish
- ☐ blood is visible
- ☐ variable
- ☐ yellow, light brown
- ☐ chalky colored
- ☐ greasy, shiny

Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

Medical Status

Gastrointestinal

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Irritable Bowel Syndrome				☐	☐
Crohn's				☐	☐
Ulcertative Colitis				☐	☐
Gastritis or Peptic Ulcer Disease				☐	☐
GERD (reflux or heartburn)				☐	☐
Celiac Disease				☐	☐
SIBO				☐	☐
Gut infections				☐	☐
Dysbiosis				☐	☐
Leaky gut				☐	☐
Food allergies, intolerances or reactions				☐	☐
Gallstones				☐	☐
Known absorption or assimilation issues				☐	☐
Other				☐	☐

Cardiovascular

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Heart attack				☐	☐
Heart Disease				☐	☐
Stroke				☐	☐
Elevated cholesterol				☐	☐

Arrhythmia (irregular heartbeat				☐	☐
Hypertension (high blood pressure)				☐	☐
Rheumatic Fever				☐	☐
Mitral Valve Prolapse				☐	☐
Other				☐	☐

Hormones/Metabolic

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Type 1 Diabetes				☐	☐
Type 2 Diabetes				☐	☐
Type 2 Diabetes				☐	☐
Metabolic Syndrome				☐	☐
Insulin Resistance or Pre-Diabetes				☐	☐
Hypothyroidism (low thyroid)				☐	☐
Hyperthyroidism (overactive thyroid)				☐	☐
Hashimoto's (autoimmune hypothyroid)				☐	☐
Grave's Disease (autoimmune hyperthyroid)				☐	☐
Endocrine problems				☐	☐
Polycystic Ovarian Syndrome (PCOS)				☐	☐
Infertility				☐	☐
Weight gain				☐	☐
Weight loss				☐	☐
Frequent weight fluctuations				☐	☐
Eating disorder				☐	☐
Menopause difficulties				☐	☐

Hair loss				☐	☐
Other				☐	☐

Cancer

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Lung Cancer				☐	☐
Breast Cancer				☐	☐
Colon Cancer				☐	☐
Ovarian Cancer				☐	☐
Prostate Cancer				☐	☐
Skin Cancer (Melanoma)				☐	☐
Skin Cancer (Squamous, Basal)				☐	☐
Other				☐	☐

Genital & Urinary Systems

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Kidney Stones				☐	☐
Gout				☐	☐
Erectile Dysfunction or Sexual Dysfunction				☐	☐
Interstitial Cystitis				☐	☐
Frequent urinary tract infections				☐	☐
Frequent Yeast Infections				☐	☐
Other				☐	☐

Musculoskeletal/Pain

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Osteoarthritis				☐	☐
Fibromyalgia				☐	☐
Chronic Pain				☐	☐
Sore muscles or joints, undiagnosed				☐	☐
Other				☐	☐

Immune/Inflammatory

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Chronic Fatigue Syndrome				☐	☐
Rheumatoid Arthritis				☐	☐
Lupus SLE				☐	☐
Raynaud's				☐	☐
Psoriasis				☐	☐
Mixed Connetive Tissue Disease (MCTD)				☐	☐
Poor immune function (frequent infections)				☐	☐
Food allergies				☐	☐
Environmental allergies				☐	☐
Multiple chemical sensitivities				☐	☐
Latex allergy				☐	☐
Hepatitis				☐	☐
Lyme (and co-infections)				☐	☐

Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, etc.)				☐	☐
Other				☐	☐

Respiratory Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Asthma				☐	☐
Chronic Sinusitis				☐	☐
Bronchitis				☐	☐
Emphysema				☐	☐
Pneumonia				☐	☐
Sleep Apnea				☐	☐
Frequent or recurrent Colds/Flus				☐	☐
Other				☐	☐

Skin Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Eczema				☐	☐
Psoriasis				☐	☐
Dermatitis				☐	☐
Hives				☐	☐
Rash, undiagnosed				☐	☐
Acne				☐	☐
Skin Cancer (Melanoma)				☐	☐
Skin Cancer (Squamous, Basal)				☐	☐
Other				☐	☐

Neurologic/Mood

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Depression				☐	☐
Anxiety				☐	☐
Bipolar Disorder				☐	☐
Schizophrenia				☐	☐
Headaches				☐	☐
Migraines				☐	☐
ADD/ADHD				☐	☐
Autism				☐	☐
Mild Cognitive Impairment				☐	☐
Memory problems				☐	☐
Memory problems				☐	☐
Multiple Sclerosis				☐	☐
ALS				☐	☐
Seizures				☐	☐
Alzheimer's				☐	☐
Other				☐	☐

Miscellaneous

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Anemia				☐	☐
Chicken Pox				☐	☐
German Measles				☐	☐
Measles				☐	☐
Mononucleosis				☐	☐
Mumps				☐	☐

Sleep Apnea				☐	☐
Whooping Cough				☐	☐
Tuberculosis				☐	☐
Known genetic variants (SNPs, polymorphisms, etc)				☐	☐
Other				☐	☐

Please check frequency of the following:

	Yes	No	Sometimes
Short term memory impairment	☐	☐	☐
Shortened focus of attention and ability to concentrate	☐	☐	☐
Coordination and balance problems	☐	☐	☐
Problems with lack of inhibition	☐	☐	☐
Poor organization abilities	☐	☐	☐
Problems with time management (late or forget appts)	☐	☐	☐
Mood instability	☐	☐	☐
Difficulty understanding speech and word finding	☐	☐	☐
Brain fog, brain fatigue	☐	☐	☐
Lower effectiveness at work, home or school	☐	☐	☐
Judgment problems like leaving the stove on, etc	☐	☐	☐

Health Hazards

Have you been directly exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

Do odors affect you?

Are you or have you been exposed to second-hand smoke?

Oral Health History

In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

Do you have any mercury amalgams? If no, were they removed? If so, how?

Do you have any concerns about your oral or dental health?

Is there anything else about your current oral or dental health or health history that you'd like us to know?

Lifestyle History

Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time

Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

How do you handle stress?

Sleep History

Are you satisfied with your sleep?

Do you stay awake all day without dozing?

Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

Do you fall asleep in less than 30 minutes?

Do you sleep between 6 and 8 hours per night?

For Women Only

How old were you when you first got your period?

How are/were your menses? Do/did you have PMS? Painful periods? If so, explain

In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

Have you experienced any yeast infections or urinary tract infections? Are they regular?

Have you/do you still take birth control pills: If so, please list length of time and type

Have you had any problems with conception or pregnancy?

Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Sexual History

Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

In the past year, have your sexual partners been men, women, or both? And how many partners have you had in the past year?

Mental Health Status

How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 = Worst, 10 = Best

At what point in your life did you feel best? Why?

Other

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no

Who in you family or on your health care team will be most supportive of you making dietary change?

Please describe any other information you think would be useful in helping to address your health concern(s):

What are your health goals and aspirations?

How will improving your health affect your life? Do you feel "ready" to make new changes to your lifestyle and diet?

Client

By signing below, I agree that I have listed all information with accuracy to the best of my ability.

X

Print Name: **Date:**