Advanced Nutritional Solutions
whysuffer.NET

CLIENT INTAKE FORM (ADULT)

Today's Date ___/___/___ Given First Name_____Like to be Called_____Middle Initial___

Last Name_____ Age _____ Gender M / F Birthdate _____/_____/____

Address_____ City _____ State ___ Zip _____

Primary Phone (_____)_____type_____ Second Phone (_____)_____type_____

Child(ren) and Age(s) _____

Email Address_____

Referred By _____

Relationship Status: Single Married Widowed Divorced Partners

Visa/MasterCard/AmEx : _____ **Expiration** ____/_____ **CVV**_____

CURRENT WELLNESS

Height _____ Weight _____ Blood Type: ____ Water Type (Well or City)_____

Daily Intake… Water: ___glasses Caffeine: ___cups Artificial Sweeteners: ___packets Cigarettes: ___packs

Soda Pop: ____cans daily / weekly diet / regular Alcohol: ____drinks daily / weekly beer / wine / liquor

Recreational Drugs (*your responses are held in strict confidentiality*): _____

Prescription Drugs: _____

_____

Nutritional Products/Vitamins: _____

_____

Known food allergies or sensitivities: _____

Sleep Patterns:_____

Bowel Movements: ___times daily / weekly Diarrhea? yes / no Constipation? yes / no

Top 3 Health Goals: _____

Top 3 Complaints, illnesses, or sicknesses: _____

Do you see a physician? yes / no Physician's name _____

Do you see a chiropractor? yes / no Chiropractor's name _____

How do you relieve stress? _____

HOW IS YOUR

Daily Energy Level?	Excellent	Good	Fair	Poor
Handling of Daily Stress Level?	Excellent	Good	Fair	Poor
Support System of Family & Friends?	Excellent	Good	Fair	Poor
Overall Enjoyment of Life?	Excellent	Good	Fair	Poor

NUTRITION & EXERCISE HABITS

How many meals do you usually eat each day? ___ Do you skip meals? yes / no ___times daily / weekly

Do you eat out? yes / no ____times daily / weekly Typical Cuisine _____

Typical Breakfast _____ Lunch _____

_____ Dinner _____ Snacks _____

_____ Food Cravings: salty / sweets / fats / carbs other _____

Exercise: ____times daily / weekly types of exercise _____

Describe your daily activity level (outside of exercise) _____

PAST WELLNESS

Childhood Illnesses_____

Childhood Viruses: cold sores / mono / acne other_____

Have you ever been in a car accident? yes / no year_____ injuries_____

When did you last have blood-work done? _____

Any Surgeries?

_____

Family History of Diseases (type & relationship) _____

_____

Mother Living? yes / no age____ cause of death _____

Father Living? yes / no age____ cause of death _____

WOMEN ONLY

At what age did you begin menstruation? _____ When was your last period? _____

Describe your menstrual cycle _____

Have you ever used Hormone Replacement Therapy (HRT)? yes / no / now Birth Control? yes / no / now

Check all that apply:

- ☐ PMS
- ☐ Pregnant
- ☐ Nursing
- ☐ Hot Flashes / Nightsweats
- ☐ No Periods
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Menopause
- ☐ Periomenopause
- ☐ Loss of Libido
- ☐ Painful Intercourse
- ☐ Hysterectomy
- ☐ Polycistic Ovaries
- ☐ Bladder Issues
- ☐ Frequent Urination
- ☐ Burning Urination
- ☐ Vaginal Yeast Infections
- ☐ Urinary Tract Infections

MEN ONLY Check all that apply:

- ☐ Frequent Urination
- ☐ Burning Urination
- ☐ Slow Urination / Dribbling
- ☐ Difficulty with Erection
- ☐ Loss of Libido
- ☐ Prostate Enlargement
- ☐ Bladder Issues
- ☐ Painful Intercourse
- ☐ Pain or Swelling

CIRCLE "C" –or– "P" FOR EVERYTHING THAT APPLIES: ***"C"*** *= CURRENT,* ***"P"*** *= PAST*

Cardiovascular
C P – Heart Disease
C P – High Blood Pressure
C P – Low Blood Pressure
C P – Heart Attack
C P – Stroke
C P – High Total Cholesterol Level
C P – High LDL-Cholesterol Level
C P – Low LDL-Cholesterol Level
C P – High Triglycerides
C P – Fainting
Other: _____

Hepatic / Liver
C P – Hepatitis A / B / C
C P – Fatty Liver
C P – Anemia (low Iron)
C P – Chemical Sensitivities
Other: _____

Neurological
C P – Severe Mood Swings
C P – Chronic Depression
C P – Suicidal Tendencies
C P – Addiction (alcohol, drugs, _____)
C P – Panic Attacks
C P – Seizures
C P – Anxiety or Nervousness
C P – Memory Loss or Confusion
C P – ADD / ADHD
C P – Autism
C P – Dyslexia
C P – Bipolar
C P – Learning Disabilities
C P – Schizophrenia
C P – Insomnia
C P – Headaches: cluster / migraine / sinus
C P – Tinnitus (ringing in the ears)
C P – Tourette Syndrome
C P – Eating Disorder _____
Other: _____

Muscle, Bone & Joint
C P – Arthritis osteo / rheumatoid
C P – Osteoporosis or Osteopaenia
C P – Exercise Limitations
C P – Chronic Pain muscles / joints
Other: _____

Circulatory
C P – Raynauds Syndrome
Other: _____

Immunology
C P – Frequent Colds or Flu
C P – Cancer: _____
C P – Chronic Fatigue
C P – Upper Respiratory Allergies
C P – Systemic Yeast Infection
C P – Recurring Ear Infections
C P – High Levels of Inflammation
C P – Auto-immune Disease
Other: _____

Sexual Health
C P – Herpes Simplex II (genital)
C P – HIV
C P – HPV
C P – STDs _____
Other: _____

Endocrinology
C P – Thyroid Condition
C P – Hypothyroidism
C P – Hyperthyroidism
C P – Graves' Disease
C P – Hashimoto's Disease
C P – Goiter
C P – Poor Hair / Nail Growth
Other: _____

Urinary / Renal
C P – Kidney Stones
C P – Bladder Infections / Cystitis
C P – Gout
Other: _____

Metabolic
C P – Diabetes Type I / Type II
C P – Difficulty Losing Weight
C P – Difficulty Gaining Weight
C P – Overweight
C P – Metabolic Syndrome
C P – Hypoglycemia
C P – Hyperglycemia
Other: _____

Dermatology
C P – Varicose Veins
C P – Cystic Acne
C P – Rosacea
C P – Thinning Skin
C P – Acne
C P – Age Spots
C P – Unusual Hair Growth on Body
C P – Thinning Hair

Dermatology cont'
C P – Psoriasis
C P – Dandruff
C P – Eczema
Other: _____

Dental
C P – Bleeding Gums
C P – Teeth Fillings / Crowns
C P – Excessive Cavities
C P – Enamel Disorders
C P – Porous Teeth
Other: _____

Gastrointestinal
C P – Ulcers
C P – Diarrhea
C P – Constipation
C P – Indigestion
C P – Hemorrhoids
C P – Bloating / Gas
C P – Hernia: inguinal / hiatus
C P – Colon Polyps
C P – Acid Reflux / Heartburn
C P – Crohn's Disease
C P – Ulcerative Colitis
C P – Diverticulosis / Diverticulitis
C P – Irritable Bowel Syndrome
C P – Parasites
C P – Candida
Other: _____

Vision
C P – Macular Degeneration
C P – Poor Night Vision
C P – Cataract
C P – Glaucoma
C P – Conjunctivitis (pink eye)
Other: _____

Respiratory
C P – Bronchitis
C P – Asthma
C P – Emphysema
C P – Sinus Infections / Polyps
C P – Pulmonary Disease
C P – Airborne Allergies
Other: _____

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ANS CANCELLATION POLICY

Last-minute cancellations deny other clients' timely access to their health practitioner. By requesting our clients agree to a cancellation fee, it reduces the number of cancellations and cuts down on your waiting room time.

- There is **NO CHARGE** if you cancel within **3** days of your appointment date.
  - **3 days or more**: no charge
  - **24-72 hours:** $25
  - **24 hours or less, no-show, no-call:** $30
  - **Saturday appointments no-show, no-call: or cancelled within 24 hours: will result in a full office visit charge***
    (**they are the most in-demand day and we usually have a wait list*)

- To assist you, ANS will provide you **one** *Courtesy Reminder,* **5-7 days** before your appointment. **Our reminder phone calls/emails are a courtesy to you. You are responsible for your appointment dates.** Note: appointments are considered confirmed when scheduled, therefore, in the unlikely event of not receiving *a Courtesy Reminder,* the fee still stands**.**

- You may call anytime to cancel. If you leave a message, be sure to leave your phone number, reason for cancellation, and the best time for us to call you back to reschedule. We can use the 'timestamp' of the voicemail to validate the time of your phone cancellation. You may also email **info@whysuffer.net** to cancel, or send text to our text-only phone number: 248-321-6649

- ANS reserves the right to waive fees or honor charges at its sole discretion.

Your Preferences:

How do you prefer to receive your Courtesy Reminders?

Email _____**Phone Call/Voicemail** ____-____-_____**Text** ____-____-_____

If a fee is assessed, you authorize Advanced Nutritional Solutions to charge your credit/debit card on file. If your card is declined, you are still responsible for the charge.

I agree to these terms and conditions (***Please Sign***):

_____ _____
Client Signature Date

_____ _____
Print name as it appears on Debit/Credit Card: Billing Zip Code

MC Visa Am Express (circle one) Card#_____
Exp___/_____ CV _____