

## Vanguard Health and Wellness Intake Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Are you pregnant?  Yes  No Due Date: \_\_\_\_\_

Please list your 5 major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list any medications you currently take and for what conditions:

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Please list any natural supplements you take and for what conditions:

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| CATEGORY 1  |   |   |   |   |
|---|---|---|---|---|
| Feeling that bowels do not empty completely           | 0 | 1 | 2 | 3 |
| Lower Abdominal pain relieved by passing gas or stool | 0 | 1 | 2 | 3 |
| Alternating constipation/diarrhea                     | 0 | 1 | 2 | 3 |
| Diarrhea  | 0 | 1 | 2 | 3 |
| Constipation  | 0 | 1 | 2 | 3 |
| Hard, Dry or small stool                              | 0 | 1 | 2 | 3 |
| Pass large amounts of foul smelling gas               | 0 | 1 | 2 | 3 |
| More than 3 bowel movements per day                   | 0 | 1 | 2 | 3 |
| Use Laxatives frequently                              | 0 | 1 | 2 | 3 |
| Bloating after eating                                 | 0 | 1 | 2 | 3 |

| CATEGORY 2                                     |   |   |   |   |
|--|---|---|---|---|
| Increase frequency of food reactions           | 0 | 1 | 2 | 3 |
| Unpredictable food reactions                   | 0 | 1 | 2 | 3 |
| Aches, pains, and swelling throughout the body | 0 | 1 | 2 | 3 |
| Unpredictable abdominal swelling               | 0 | 1 | 2 | 3 |
| Frequent bloating and distention after eating  | 0 | 1 | 2 | 3 |

| CATEGORY 3                                     |   |   |   |   |
|--|---|---|---|---|
| Intolerance to smells                          | 0 | 1 | 2 | 3 |
| Intolerance to jewelry                         | 0 | 1 | 2 | 3 |
| Intolerance to shampoo, lotion, detergent, etc | 0 | 1 | 2 | 3 |
| Frequent skin outbreaks                        | 0 | 1 | 2 | 3 |

| CATEGORY 4                               |   |   |   |   |
|--|---|---|---|---|
| Excessive belching, bloating or burping  | 0 | 1 | 2 | 3 |
| Gas Immediately following a meal         | 0 | 1 | 2 | 3 |
| Offensive breath (halitosis)             | 0 | 1 | 2 | 3 |
| Difficult bowel movement                 | 0 | 1 | 2 | 3 |
| Sense of fullness during and after meals | 0 | 1 | 2 | 3 |
| Difficulty digesting proteins            | 0 | 1 | 2 | 3 |
| Undigested food found in stools          | 0 | 1 | 2 | 3 |

| CATEGORY 5  |   |   |   |   |
|---|---|---|---|---|
| Stomach pain, burning, or aching 1-4 hours after eating                     | 0 | 1 | 2 | 3 |
| Use of antacids   | 0 | 1 | 2 | 3 |
| Feel hungry 1-2 hours after eating  | 0 | 1 | 2 | 3 |
| Heartburn when lying down or leaning forward                                | 0 | 1 | 2 | 3 |
| Temporary relief by using antacids, food, milk, or carbonated beverages     | 0 | 1 | 2 | 3 |
| Digestive problems subside with rest and relaxation                         | 0 | 1 | 2 | 3 |
| Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, caffeine | 0 | 1 | 2 | 3 |

| CATEGORY 6  |   |   |   |   |
|---|---|---|---|---|
| Difficulty digesting roughage and fiber                               | 0 | 1 | 2 | 3 |
| Pain, tenderness, or soreness on the left side under rib cage         | 0 | 1 | 2 | 3 |
| Nausea and/or vomiting  | 0 | 1 | 2 | 3 |
| Stool undigested, foul smelling, mucus like, greasy, or poorly formed | 0 | 1 | 2 | 3 |
| Frequent loss of appetite   | 0 | 1 | 2 | 3 |

| CATEGORY 7                               |   |   |   |   |
|--|---|---|---|---|
| Greasy or high fat foods cause distress  | 0 | 1 | 2 | 3 |
| Yellowish cast to eyes                   | 0 | 1 | 2 | 3 |
| History of gallbladder attacks or stones | 0 | 1 | 2 | 3 |
| Have you had your gallbladder removed?   | Y | N |   |   |

| CATEGORY 8                    |   |   |   |   |
|-------------------------------|---|---|---|---|
| Acne and unhealthy skin       | 0 | 1 | 2 | 3 |
| Excessive hair loss           | 0 | 1 | 2 | 3 |
| Overall sense of bloating     | 0 | 1 | 2 | 3 |
| Bodily swelling for no reason | 0 | 1 | 2 | 3 |
| Weight gain                   | 0 | 1 | 2 | 3 |
| Constipation                  | 0 | 1 | 2 | 3 |
| Excessive foul smelling sweat | 0 | 1 | 2 | 3 |

| CATEGORY 9                                 |   |   |   |   |
|--|---|---|---|---|
| Crave sweets during the day                | 0 | 1 | 2 | 3 |
| Irritable if meals are missed              | 0 | 1 | 2 | 3 |
| Depend on coffee to keep going/get started | 0 | 1 | 2 | 3 |
| Eating relieves fatigue                    | 0 | 1 | 2 | 3 |
| Feels shaky, jittery or tremors            | 0 | 1 | 2 | 3 |
| Blurred vision                             | 0 | 1 | 2 | 3 |

| CATEGORY 10                                       |   |   |   |   |
|---|---|---|---|---|
| Fatigue after meals                               | 0 | 1 | 2 | 3 |
| Eating sweets does not relieve cravings for sugar | 0 | 1 | 2 | 3 |
| Frequent urination                                | 0 | 1 | 2 | 3 |
| Increased thirst and appetite                     | 0 | 1 | 2 | 3 |

| CATEGORY 11                                       |   |   |   |   |
|---|---|---|---|---|
| Tired/sluggish                                    | 0 | 1 | 2 | 3 |
| Feel cold – hands, feet, all over                 | 0 | 1 | 2 | 3 |
| Increase in weight even with low calorie diet     | 0 | 1 | 2 | 3 |
| Difficult, infrequent bowel movements             | 0 | 1 | 2 | 3 |
| Depression/lack of motivation                     | 0 | 1 | 2 | 3 |
| Outer third of eyebrow things                     | 0 | 1 | 2 | 3 |
| Thinning of hair on scalp, face, genitals or head | 0 | 1 | 2 | 3 |

| CATEGORY 12                 |   |   |   |   |
|-----------------------------|---|---|---|---|
| Heart palpitations          | 0 | 1 | 2 | 3 |
| Inward trembling            | 0 | 1 | 2 | 3 |
| Increase pulse even at rest | 0 | 1 | 2 | 3 |
| Nervous and emotional       | 0 | 1 | 2 | 3 |
| Insomnia                    | 0 | 1 | 2 | 3 |

| CATEGORY 13                    |   |   |   |   |
|--------------------------------|---|---|---|---|
| Night Sweats                   | 0 | 1 | 2 | 3 |
| Difficulty gaining weight      | 0 | 1 | 2 | 3 |
| Recent unexplained weight loss | 0 | 1 | 2 | 3 |

| CATEGORY 14 (Males Only)             |   |   |   |   |
|--------------------------------------|---|---|---|---|
| Urination difficulty or dribbling    | 0 | 1 | 2 | 3 |
| Frequent urination                   | 0 | 1 | 2 | 3 |
| Feeling of incomplete bowel emptying | 0 | 1 | 2 | 3 |

| CATEGORY 15 (Males only)                          |   |   |   |   |
|---|---|---|---|---|
| Decreased libido                                  | 0 | 1 | 2 | 3 |
| Decreased number of spontaneous morning erections | 0 | 1 | 2 | 3 |
| Decreased fullness of erections                   | 0 | 1 | 2 | 3 |
| Spells of mental fatigue                          | 0 | 1 | 2 | 3 |
| Inability to concentrate                          | 0 | 1 | 2 | 3 |
| Episodes of depression                            | 0 | 1 | 2 | 3 |
| Decreased physical stamina                        | 0 | 1 | 2 | 3 |
| Increased fat in chest and hips                   | 0 | 1 | 2 | 3 |
| Sweating attacks                                  | 0 | 1 | 2 | 3 |

| CATEGORY 16 (menstruating females only)         |   |   |   |   |
|---|---|---|---|---|
| perimenopausal                                  | Y | N |   |   |
| Alternating cycle lengths                       | Y | N |   |   |
| Extended menstrual cycle (greater than 32 days) | Y | N |   |   |
| Shortened menstrual cycle (les than 24 days)    | Y | N |   |   |
| Pain and cramping during menstrual cycle        | 0 | 1 | 2 | 3 |
| Scanty blood flow                               | 0 | 1 | 2 | 3 |
| Heavy blood flow                                | 0 | 1 | 2 | 3 |
| Irritable and depressed during menses           | 0 | 1 | 2 | 3 |
| Acne  | 0 | 1 | 2 | 3 |
| Facial hair growth                              | 0 | 1 | 2 | 3 |

| CATEGORY 17 (females only)                         |   |   |   |   |
|--|---|---|---|---|
| Are you menopausal? For how many years?            |   |   |   |   |
| Since menopause, do you ever have uterine bleeding | Y | N |   |   |
| Hot flashes  | 0 | 1 | 2 | 3 |
| Mental fogginess                                   | 0 | 1 | 2 | 3 |
| Disinterest in sex                                 | 0 | 1 | 2 | 3 |
| Mood swings  | 0 | 1 | 2 | 3 |
| Depression   | 0 | 1 | 2 | 3 |
| Painful Intercourse                                | 0 | 1 | 2 | 3 |
| Shrinking breasts                                  | 0 | 1 | 2 | 3 |
| Acne   | 0 | 1 | 2 | 3 |
| Increased vaginal pain, dryness or itching         | 0 | 1 | 2 | 3 |

0= least/never 3=most/always