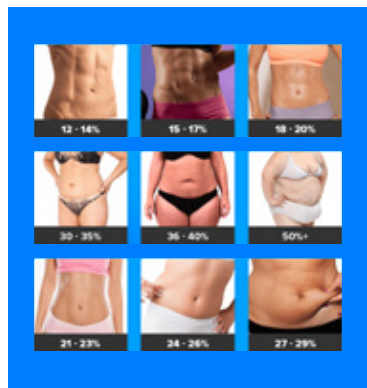




CLIENT INTAKE FORM

PERSONAL INFORMATION

- Name _____
- Phone Number _____
- Age _____
- Birth Date _____
- Gender _____
- Height _____
- Body Fat Percentage _____
- Current Weight _____
- Goal Weight _____
- Weight One Year Ago _____



LIFESTYLE

- How many hours of sleep per night?

- Do you exercise? If so, how often? Cardio? Weights?

- Do you drink alcohol? How much?

- Do you smoke cigarettes? How often?

- Do you do recreational drugs? What and how often?

- Children? Ages?

- What is your family living situation?

- What do you do for work?

- What do you do for fun?

- On a scale of 1-10, one being the least and 10 being the most, what is your current stress level?

- What is the cause of your stress?

- Have you had any recent life changes or big events?

HEALTH HISTORY

- Current medications

- Did you take antibiotics a lot as a child?

- Do you have a bowel movement at least once per day?

- Have you ever been diagnosed with IBS or GERD?

- Are you diabetic?

- Do you have any hormonal issues?

- Is your period regular?

- Do you have any thyroid issues or concerns?

- Have you ever or do you currently suffer from depression or anxiety?

- Any injuries?

- Please list all surgeries:

- Do any chronic diseases run in your family?

- Any other health concerns or conditions?

FOOD

- Any food allergies?

- Favorite food?

- Foods you do not like?

- Do you ever emotionally eat?

- Do you eat out of boredom?

- What does a typical day of eating look like for you?

- What do you like to order when dining at a restaurant?

- How many glasses of water per day do you drink?

IT'S ALL ABOUT YOU!

- What are your health goals and aspirations?

- Why are these important to you?

***** Please fill out this form and save it as "First Name Last Name" and submit to bob@keto-initiative.com *****