The Institute of Nutritional Endocrinolgy

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Discovery Consult Intake Form

We look forward to meeting with you to review your health history and habits. During our consultation we will use this information to identify your health challenges and goals and strategize some immediate action steps, as well as long-term options for guiding you on your journey to create vibrant health.

Please take a few minutes to thoughtfully answer the following questions so as to acquaint us with the symptoms and health issues that have prompted you to seek help. Be as thorough as possible in answering the questions and if there is something that you're not sure about, write unsure and we can explore it together during our session.

Name					Date		
Age		Date of Birth		Height		Weight	
Occupation					Employer		
E-Mail Address							
Street Address			City		State	ZIP	
Phone Home		Mobile		Work		Fax	
Marital Status		Partner's Name:					
If you have children, what are their names and ages?							
In Case of EMERGENCY Notify				Phone			

Please describe in as much detail as possible your reasons for setting up this appointment. If specific health challenges prompted you, provide as much detail as possible.

What are your top 5 health concerns, in priority order?

On a scale from 1 to 10, how important is it for you to get these health concerns solved?

What are your top 3 health goals? Please CIRCLE your top priority.

1	
2	
3	

What interventions have you taken, to date, to address your health concerns? Please describe in as much detail as possible, including treatments, programs, diets, supplements, drugs, surgery or other interventions. Provide information on the effectiveness of these and the ones you continue to do.

If you are currently under the care of any health care practitioner, please indicate what type of practitioner and for what purpose. Write NONE if you are not currently seeing any health practitioners.

List the top five priorities in your life. That is, what five things do you value above all else?

What habits do you currently have that positively influence your health?

What habits do you currently have that negatively influence your health?

On a scale of 0 to 10, rate your average stress level.

What are the major stressors in your life?

List any medications you take and for what purpose. Include prescription and over the counter. Write NONE if you don't take any.

Please list any surgeries, hospitalizations, accidents and major illnesses and injuries. Include approximate date or age and indicate whether the incident continues to impact your health.

List any nutritional supplements or herbs you take and indicate why you take each. Write NONE if you don't take any.

What are the 3 worst foods you eat in a week?

What are the 3 healthiest foods you eat in a week?

How many alcoholic beverages do you consume per week?

How many caffeinated beverages do you consume per week?

How many times do you eat out per week?

How many times do you eat raw nuts or seeds?

How many times do you work out per week?

If you work out, what type of exercise do you do?

Do you smoke?

If you smoke, what do you smoke and how much?

Have you smoked in the past?

If you are an ex-smoker, what do you smoke, how much and when did you quit?

List any toxic exposures you currently have or have had over the past 5 years. This includes industrial chemicals, paints, pesticides, molds and chemicals in water.

What is the one thing you'd most like to get out of our first session together?

Thanks so much for taking the time to fill out this form. It will help me to better understand your needs and challenges and hone in on how I may best support you to achieve your health goals.