CLIENT INTAKE FORM
(all information is kept confidential)

Name_____Date_____Referred By_____

Address_____City_____State_____Zip_____

Phone(____)_____Cell Phone(____)_____Email_____

Occupation_____Hours per week_____ Work Phone(____)_____

Date of Birth_____Height_____Weight_____Blood Type_____

Emergency Contact and Phone_____

MAJOR HEALTH CONCERNS OR GOALS

1)_____2)_____3)_____

List all medications, drugs, over the counter products, etc. taking, for how long & why

_____

_____

List all herbs, vitamins, supplements, homeopathics, etc. taking, for how long & why

_____

_____

List your favorite foods that you eat on a regular basis and any cravings

_____

Do you have gas, bloating or other digestion problems? Please explain.

_____

Number of hours sleep at night____ Explain any troubles with sleep _____

_____

What is your energy like throughout the day? Any times lower than others?_____

_____

WOMEN ONLY

Are you pregnant Y or N Trimester 1 2 3 Past Pregnancies_____

Miscarriage Y or N

Abortion Y or N

Regular periods Y or N

PMS Y or N

Yeast Infections Y or N

Urinary Tract Infections Y or N

Explanations_____

DIET/HABITS	YES	USED TO (number years?)	NO	NUMBER DAILY	NUMBER WEEKLY
COFFEE or CAFFEINE					
ALCOHOL					
SODA (Diet or Regular?)					
CIGARETTES					
SWEETS					
FAST FOOD					
PREPACKAGED FOOD					
MICROWAVED FOOD					
MARGARINE					
ARTIFICIAL SWEETENER					
LAXATIVES					
ANTACIDS					
ANTIBIOTICS					
PAIN KILLERS					
EXERCISE (30 minutes)					
WATER (8 glasses)					

MEDICAL HISTORY

Have you ever been diagnosed with any health conditions? (include dates)

_____

_____

_____

Cholesterol Level_____ Triglycerides_____ Blood Pressure_____ Blood Sugar_____

What type of water do you drink?_____ How many glasses per day?_____

Do you have water filters in your house? (type?)_____ Are you often in swimming pools?___

Do you have any allergies that you are aware of?

_____

_____

List all surgeries and dates

_____

_____

List any concerns or problems other than what has been diagnosed

_____

_____

The above information is, to the best of my knowledge, true and factual.

Signature _____ Date _____

PERMISSION AND AUTHORIZATION FORM
Sheryl Shenefelt, CN

PLEASE READ BEFORE SIGNING:

I understand and agree that Sheryl Shenefelt, CN is developing a program for me designed to improve my health and NOT for treatment or "cure" of any disease or other health condition.

I understand that Sheryl is not "diagnosing" or "treating" any disease including cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

I understand that my ability to improve my health or weight depends on my choices and behavior and Sheryl has made no warranties regarding her recommendations.

I understand that no promise or guarantee has been made regarding the results of any natural health, nutritional or dietary programs recommended.

I understand that whole foods and other recommendations are possible means by which the body can naturally overcome nutritional imbalances, and that the natural programs developed are for the purpose of bringing about a more optimum state of health.

I understand that, unless I give 24 hours notice, I will be charged for cancelled appointments. I have read and understand the foregoing. This permission and authorization form applies to subsequent visits and consultations.

Printed Name_____ Date_____

Address_____

City_____State_____Zip_____

Phone(_____)_____Email_____