Restoring your health. Revitalizing your life.

SHAPE ReClaimed Intake Form

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Sex: ☐ Male ☐Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____

Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Names and ages of children: _____

How did you hear about the SHAPE ReClaimed program? _____

What health benefits do you want to achieve with the SHAPE ReClaimed program?

☐ Improved eating habits ☐ Improved well-being ☐ Decreased inflammation ☐ Weight reduction

☐ Increased energy ☐ Improved sleep ☐ Increased stamina ☐ Other _____

Physical Health

Height: _____ Weight: _____

Are there any areas of your body that are not functioning optimally? ☐ No ☐ Yes

If yes, what forms for stretching do you perform? _____

On average, how many hours do you sleep per night? ☐ <5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you wake up feeling refreshed? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes

If yes, why and when: _____

Have you been diagnosed with any clinical condition or disease? ☐ No ☐ Yes

If yes, what: _____

Have you ever been in a motor vehicle accident? ☐ No ☐ Yes

If yes, what kind and when: _____

Were you evaluated and treated after each accident? ☐ No ☐ Yes

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes

If yes, please explain: _____

Have you had any imaging performed in the last year? ☐ No ☐ X-ray ☐ MRI ☐ US ☐ PET

Have you had blood work performed in the last year? ☐ No ☐ Yes

Were your test results in medically normal ranges? ☐ No ☐ Yes

If not, which results were abnormal? _____

Mental/Emotional Health

Rate the current level of **personal stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **relationship stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **health stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **family stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **occupational stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

How do you manage the stress in your life? _____

Chemical Health

Do you choose to get annual flu shots? ☐ No ☐ Yes

Have you used antibiotics in the last year? ☐ No ☐ Yes

How many cups of water do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of coffee/energy drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of juice/soda/sports drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods)? ☐ No ☐ Yes

If yes, how many servings per day? _____

Do you eat refined sugar? ☐ No ☐ Yes

If yes, how many servings per day? _____

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum)? ☐ No ☐ Yes

Do you have any food/drink allergies, sensitivities or intolerances? ☐ No ☐ Yes: _____

Do you smoke? ☐ No ☐ Yes ☐ I used it for: _____ years

Are you/have you been exposed to second-hand smoke? ☐ No ☐ Yes

Do you take probiotics? ☐ No ☐ Yes

Do you take Vitamin D? ☐ No ☐ Yes

Do you take Omega-3? ☐ No ☐ Yes

Other supplements or homeopathics: _____

Please list any medications that you take regularly and why: _____

_____

_____

Food Health

Please list the foods you commonly eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many cups of vegetables do you eat per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

What foods do you crave? _____

Please state specifically what your goals are with this program: _____

_____

I _____, hereby grant permission to receive a professional and complete physical examination and consultation, including urinalysis and evaluation.

_____ _____

Patient Signature Date

Reviewed December 2018