



Sweet Life Clinic Consultation Intake Form

Date: _____

Name: _____ Age: _____ Sex: M F

Address: _____

Phone: (day) _____ (evening) _____

e-mail: _____ Birth date: _____

What would you like help with at this time?

Present physical complaints: _____

Onset and length of symptoms: _____

At or around the time of onset were other emotional stresses occurring? _____

List any medications you are presently taking: _____

List any Herbal Medicines, Supplements, Homeopathics, Over the Counter Medications you are presently taking: _____

PAST MEDICAL HISTORY

Surgical History: _____

Other Hospitalizations: _____

Serious accidents, falls or injuries: _____

Any childhood accidents or physical traumas? _____

Do You Have Any Allergies? _____ To What? _____

Present Weight: _____ One Year Ago: _____ 5 Years Ago: _____

WOMEN'S HEALTH

Do you experience any of the following, past or present? PLEASE CIRCLE

Breast pain	Fibroids	Hot flashes
Irregular PAP	Vaginal dryness	Difficult menopause
Difficulty getting pregnant	Ovarian cysts	Pelvic pain
Endometriosis	Vaginal infection	Currently pregnant
STD's including HPV	Irregular menstrual cycles	

How many pregnancies? ___ Number of deliveries: ___ Vaginal ___ C-Section

Any complications? _____

Any problems post-partum _____

Have you had any miscarriages? ___ If so, when? _____

Have you had any abortions? ___ If so, when? _____

Method of contraception: _____

Do you have an IUD ? _____

Do you have any pain with intercourse? _____

Do you have difficulty achieving orgasm? _____

Do you have any problems with incontinence (difficulty holding your urine)? _____

Date of Last Menstrual Period? _____

MENSTRUAL PATTERN (check all that apply):

Symptom	Yes	No	Explanation
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Painful Menstruation

Clots

Irregular Cycles

Dark Blood at Onset

Dark Blood at Conclusion

Heaviness in Lower Pelvis

Weak or Numb Legs

Other:

How many days do you bleed?

Light, medium or heavy flow?

Date of last pelvic exam?

Have you ever been told you have a tipped or tilted uterus?

MENOPAUSE:

Have you entered Menopause yet? _____ If so, at what age? _____

Please check below if you have experienced any of the following:

Hot Flashes ___ Memory Loss ___ Depression ___

Insomnia ___ Mood Swings ___ Fatigue ___

Do any of the women on your mother's side of the family suffer from any of the following:

Infertility ___ Menstrual Problems ___ Difficult Menopause ___

Are you now, or have you ever taken: Birth Control Pills ___ Hormone Replacement Therapy? ___

GENERAL

Do you have or have you had any of the following?

High Blood Pressure ___	Acne ___	Anorexia/Bulemia ___
Diabetes ___	Headaches ___	Heart Problems ___
Hepatitis ___	Skin Rashes ___	Kidney Problems ___
Cancer ___	Skin Fungus ___	Fainting Spells ___
Frequent Cold or Flu ___	Sinus Problem ___	Emotional Problems ___

FAMILY HISTORY (List any medical conditions, problems in family members)

LIFESTYLE

Tobacco Use: Yes No How Much and How Often: _____

Alcohol Use: Yes No How Much and How Often: _____

Caffeine Use: Yes No How Much and How Often: _____

Other Drug Use: Yes No How Much and How Often: _____

How frequently do you exercise? Daily ___ Weekly ___ Rarely ___

Type of exercise: _____

DIET

Breakfast: _____

Lunch: _____

Dinner: _____

How many meals a week do you dine out? _____

How many times a week do you have:

Beef ___	White Rice ___	Soda Pop ___
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Pork ___	White Bread ___	Coffee ___
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Fish ___	Crackers ___	Black Tea ___
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Chicken ___	Chips ___	Milk ___
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Canned Foods ___	Ice Cream ___	Other Dairy ___
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Desserts ___

How many glasses of water do you drink daily? _____

What would you say is the worst thing that you do on your diet? _____

Are you subject to binge eating? ___ Of what foods? _____

What food do you find to be your weakness? _____

DIGESTION

Appetite: good fair poor Explanation: _____

Digestion: good fair poor Explanation: _____

Do you experience Bloating or Gas after meals? ___ Sour burps or heartburn? ___

Do you feel Sleepy or Tired after meals? ___ How often? Daily /Weekly /Occasional

Are you on a Restricted Diet? ___ Explain: _____

ELIMINATION

How often do you have a bowel movement? Daily ___ Times per Week Irregular ___
Do you ever have hard stools? ___ Do you ever have loose stools? ___
Urination: normal ___ scanty ___ more than 5 times daily ___ burning ___ strong odor ___ dark color ___
Any history of bladder or kidney infections? ___ If so, at what age? _____

STRESS LEVEL

What would you rate your level of stress (0= no stress, 10 = maximum stress) _____
What are the major sources of stress in your life? _____
Who provides you support in your life? _____
How many hours of sleep do you get on an average night? _____
Do you usually wake up feeling tired ___ or rested ___?
Nerves: good ___ fair ___ poor ___
Anxiousness: often ___ sometimes ___ seldom ___
Depression: often ___ sometimes ___ seldom ___
Please explain your responses: _____

EMOTIONAL AND SPIRITUAL

If romantically involved, how is your relationship? _____

Were there any emotional traumas in your early or present life? Please explain briefly.
(ie. rape, great loss, suicide or death of a loved one, etc.) _____

If possible, please explain what you feel to be your most experienced negative emotion:

When do you most often feel this emotion? _____
Where are you, when you feel this negative emotion? _____
What is your opinion of yourself? _____
Have you ever been to counseling? ___ What was the outcome for you? _____

Do you meditate? ___ If so, how often? _____

Rate Yourself: None Some Lots

Faith

Hope

Charity

Generosity

Humor

Fun

Is there an unrealized longing in your life? ___ What is it? _____

Briefly explain your relationship with each of your parents? _____

WORK AND RECREATIONAL ACTIVITIES

Occupation: _____

Do you enjoy your work? _____

Are you involved with activities outside of work? _____

If so, what type of activities? _____

Do you have any hobbies or interests? _____

Do you have a satisfying love life? _____