



Sweet Life Clinic
Mini Consultation Intake Form

Date: _____

Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Age: _____

E-mail: _____ May we contact you? Yes No

Your personal information is completely confidential. We will never share it with anyone.

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

Nervous System:

Memory Loss _____

Fatigue _____

Depression _____

Headaches _____

Insomnia _____

What would you rate your level of stress (0= no stress, 10 = maximum stress) _____

How many hours of sleep do you get on an average night? _____

Heart:

High Blood Pressure _____

Varicose Veins _____

Heart Problems _____

High Cholesterol _____

Skin:

Acne _____

Eczema _____

Skin Rashes _____

Psoriasis _____

Skin Fungus _____

Digestive/Liver:

Constipation _____

Diarrhea _____

Bloating _____

When was the last time you took antibiotics? _____

Do you have a bowel movement: 1 or more times a day ___ Less frequent ___ If so, how often? _____

Food Allergies/Sensitivities Yes No If so, what are you allergic/sensitive to? _____

Have you ever done a fast or liver cleanse? Yes No If so, when? _____

Kidney:

- Kidney Problems _____
- Urinary Tract Infections _____
- Fainting Spells _____
- How much water do you drink every day? _____

Immune:

- Frequent Cold or Flu _____
- Wounds Heal Slowly _____
- Frequent Cold Sores _____
- Swollen Lymph Nodes _____

Women's Health:

- Irregular PAP _____
- Fibroids _____
- Endometriosis _____
- Difficulty Getting Pregnant _____
- Difficult Menopause _____
- Hot Flashes _____
- Currently Pregnant _____

Men's Health:

- Frequent Urination _____
- Reproductive Issues _____
- Prostate Problems _____
- Painful Urination _____

Respiratory:

- Sinus Problems _____
- Smoker _____
- Lung Problems _____
- Air-borne Allergies _____
- Asthma _____

Metabolic:

- Diabetes _____
- Hold Extra Weight in Torso/Stomach _____
- Feel Agitated/Low Functioning if Not Eating Regularly _____

List any medications you are currently taking: _____

List any know allergies: _____

Recommended Follow Up:

Complicated health issues: 1 • 2 weeks Moderate Health Issues: 2 • 4 weeks Healthy follow up: as needed

Please Note:

We do not diagnose or prescribe. Our services are strictly educational, offering clients the tools to enhance their own well-being and help them make educated decisions about their own health care. Herbal therapeutics are not meant to replace medical diagnosis or treatment. If symptoms persist, please contact your doctor.

I understand and agree to the above terms.

Name: _____ Date: _____