Please print clearly. All of your information will remain confidential between you and your health care provider.

PERSONAL INFORMATION

|  |  |
| --- | --- |
| First Name: |  |

|  |  |
| --- | --- |
| Last Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Email: |  | How often do you check email? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone: Home: |  | Work: |  | Mobile: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Age: |  | Height: |  | Birthdate: |  | Place of Birth: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Current weight: |  | Weight six months ago: |  | One year ago: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Would you like your weight to be different? |  | If so, what? |  |

SOCIAL INFORMATION

|  |  |
| --- | --- |
| Relationship status: |  |

|  |  |
| --- | --- |
| Where do you currently live? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Children: |  | Pets: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Occupation: |  | Hours of work per week: |  |

HEALTH INFORMATION

|  |  |  |
| --- | --- | --- |
| Please list your main health concerns: | |  |
|  |  | |
|  |  | |

|  |  |  |
| --- | --- | --- |
| Other concerns and/or goals? | |  |
|  |  | |

|  |  |
| --- | --- |
| At what point in your life did you feel best? |  |

|  |  |  |
| --- | --- | --- |
| Any serious illnesses/hospitalizations/injuries? | |  |
|  |  | |

HEALTH INFORMATION (continued)

|  |  |
| --- | --- |
| How is/was the health of your mother? |  |

|  |  |
| --- | --- |
| How is/was the health of your father? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What is your ancestry? |  | What blood type are you? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How is your sleep? |  | How many hours? |  | Do you wake up at night? |  |

|  |  |
| --- | --- |
| Why? |  |

|  |  |
| --- | --- |
| Any pain, stiffness, or swelling? |  |

|  |  |
| --- | --- |
| Constipation/Diarrhea/Gas? |  |

|  |  |
| --- | --- |
| Allergies or sensitivities? Please explain: |  |

WOMEN’S HEALTH

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are your periods regular? |  | How many days is your flow? |  | How frequent? |  |

|  |  |
| --- | --- |
| Painful or symptomatic? Please explain: |  |

|  |  |
| --- | --- |
| Reached or approaching menopause? Please explain: |  |

|  |  |
| --- | --- |
| Birth control history: |  |

|  |  |  |
| --- | --- | --- |
| Do you experience yeast infections or urinary tract infections? Please explain: | |  |
|  |  | |

MEDICAL INFORMATION

|  |  |  |
| --- | --- | --- |
| Do you take any supplements or medications? Please list: | |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| Any healers, helpers, or therapies with which you are involved? Please list: | |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| What role do sports and exercise play in your life? | |  |
|  |  | |

FOOD INFORMATION

|  |
| --- |
| What foods did you eat often as a child? |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| What is your food like these days? |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you cook? |  | What percentage of your food is home-cooked? |  |

|  |  |
| --- | --- |
| Where do you get the rest from? |  |

|  |  |  |
| --- | --- | --- |
| Do you crave sugar, coffee, cigarettes, or have any major addictions? | |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| The most important thing I should do to improve my health is: | |  |
|  |  | |

ADDITIONAL COMMENTS

|  |  |  |
| --- | --- | --- |
| Anything else you would like to share? | |  |
|  |  | |
|  |  | |
|  |  | |

NOTE TO CLIENTS: For all scheduled appointments, if the client needs to cancel or reschedule the appointment, we request that the client kindly provide us with **24 hours advance notice**. If such notice is not provided, the client will be charged a $100 cancellation fee for the cancelled appointment.

Please sign in the space provided below and return to the offices of Integrative Rx Solutions, LLC by email at DrMelodyk@integrativerxsolutions.com By signing, you acknowledge that (i) the information provided on this form is true and correct to the best of your knowledge, (ii) that you have fully reviewed and accept our company’s disclaimer and policy disclosure found on our website at [www.integrativerxsolutions.com](http://www.integrativerxsolutions.com) and (iii) you will abide by your written agreement with Integrative Rx Solutions, LLC and make timely payment for all services and applicable cancellation charges provided by our company and its partner service providers.

Client Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

name date