Client Intake Form

Please complete to the best of your ability and bring to your initial appointment.

Full Name: _____

Address: _____

City: _____ Postal Code: _____ Phone Number: _____

Email: _____

Gender: M F

Date of Birth: (month/day/year): _____

Age: _____ Height: _____ Weight: _____

Are you pregnant? _____
Do you have a heart condition and/or a Pacemaker? _____

How did you hear about BIE? _____

Blood Type: A B AB O

Occupation:

Main health concerns / goals:

"I haven't felt well since…":

Please circle all conditions that apply. Add more on the last page of this form, if necessary.

ADD	Food Sensitivities / Intolerances	Neuralgia
ADHD	GERD	Obsessive Compulsive Disorder
Allergies	Gingivitis	Overweight
Alzheimers	Gout	Osteoarthritis
Anemia	Heart Attack	Osteoporosis / Osteopenia
Anxiety	Heartburn	Parkinson's Disease
Autism	High blood pressure	Poly Cystic Ovarian Syndrome
Autoimmune Conditions	High cholesterol	Psoriasis
Cancer	Hypoglycemia	Rheumatoid Arthritis
Candidiasis	Inflammatory Bowel Disease	Sciatica
Cardiovascular Disease	Insomnia	Sjogren's Syndrome
Cataracts	Intestinal Strictures	Spider veins
Colitis	Irritable Bowel Syndrome	Stroke
Crohn's Disease	Low blood pressure	Thrush
Depression	Macular Degeneration	Tinnitus
Diabetes Type 1	Metabolic Syndrome	Ulcers
Diabetes Type 2	Migraines	Underweight
Eczema	Multiple Sclerosis	Varicose veins
Edema	Nail fungus	Yeast infections

What do you believe is/are the reason(s) for your condition(s)?

Please circle all signs and symptoms that apply. Add more on the last page of this form, if necessary.

Abdominal distension	Dry lips	Oily skin
Acid reflux	Dry skin	Overall negative mood
Acne	Fatigue	Pain all over
Abnormal hair growth	Flatulence	Prostate issues
Abnormal hair loss	Frequent colds/flus	Sexual dysfunction
Abnormal weight gain	Frequent urination	Skin redness / irritation
Abnormal weight loss	Gas	Skin tags

Bloating	Headaches	Sore joints
Bruise easily	Heart palpitations	Stiff joints
Cannot relax mentally	Hot flashes	Rashes
Cavities	Intestinal cramping	Tingling
Constipation (Less than 1 BM/day)	Low energy	Unmanageable stress / emotions
	Mucus or phlegm	Wake up in middle of night
Dandruff	Night sweats	Wake up unrested
Diarrhea	Numbness	Weak nails
Dry mouth	Oily scalp	

Do you have a Pacemaker or other internal device that controls the heart?

Recent diagnoses:

Surgeries (please include dates):

Past conditions including childhood illnesses (please include dates):

List all vaccinations (please include dates):

Physical traumas and accidents (please include dates):

Medications	Reason for Taking	Length of Time Taken

Supplements	Reason for Taking	Length of Time Taken

Do you drink alcohol? If yes, how much and how frequently?

Do you currently smoke?

Have you smoked in the past? If so, when did you quit?

Are you exposed to second hand smoke on a regular basis? Have you been exposed in the past?

Do you have any allergies?

Do you crave any foods frequently?

Are there foods that cause physical or emotional issues?

Exercise type(s):

How often do you exercise per week?

How many hours per night do you sleep?

Do you wake up during the night?

Do you wake feeling rested?

Can you fall asleep easily?

Hobbies / interests:

Stress level: Low 1 2 3 4 5 6 7 8 9 10 High

Do you use any methods to manage stress?

How frequently do you have a bowel movement?

Bowel movement types (please circle all that apply):

Strained	Loose	Soft	Hard	Narrow	Explosive
Floating	Bloody	Mucus	Mushy	Pale-coloured	Undigested food

Alternating hard and soft day-to-day

Female clients:

Are you pregnant?

Average length of menstrual cycle:

Do cycle lengths fluctuate?

Are you currently using birth control? If so, what method(s)?

Please circle all that apply during or just before your period:

Cramping	Breast tenderness	Looser stools	Anxiety
Depression	Night sweats	Yeast infections	Food cravings
Bloating	Swelling of face	Fatigue	Heart palpitations
Headaches	Confusion	Irritability	
Fainting	Menstrual flow is heavy-light-heavy during one period		

Other symptoms:

Use this space to expand on any details that you feel are necessary:

Client Signature: _____ Date: _____