RAW Functional Nutrition

Adult Intake Form

Complete this form to the best of your knowledge and as detailed as possible. This should take about 40 minutes to complete but it helps me significantly! Thank you :).

Personal Information

Legal first name

Last name

Street

Unit

City

State/Province

Postal Code

Home Phone

Mobile Phone

Email Address

Date of Birth

Gender

Relationship Status

Occupation

Hours Per Week

Referred By

Primary Physician

Title

Legal first name

Last name

Work Phone

Mobile Phone

Fax Number

Email Address

Occupation

List your current health concerns in order of importance

Health Concerns

Health Insurance

Policy Holder

First Name

Last Name

Date of Birth

Phone

Gender

Street

Unit

City

State/Province

Postal Code

Insurance Company

Payer Id

Coverage Type

Member Id

Plan Id

Group Id

Copay

Deductible

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Medications / Supplements

Have you ever taken antibiotics? ◯ Yes ◯ No

Have you ever taken birth control? ◯ Yes ◯ No

Have you ever been on hormone replacement therapy? ◯ Yes ◯ No

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

Digestive

Do you experience digestive difficulties?

(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement? ◯ Yes ◯ No

Are your bowels loose? ◯ Yes ◯ No

Do you take laxatives? ◯ Yes ◯ No

Allergies

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Do you avoid these foods? ◯ Yes ◯ No

Diet

How much water do you drink daily?

Do you consume coffee? ◯ Yes ◯ No

Do you consume tea? ◯ Yes ◯ No

Do you consume alcohol? ◯ Yes ◯ No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Where do you grocery shop?

Do you experience any symptoms after meals?

Describe your relationship with food

Please be specific

Anthroprometrics

Physical Assessment

Height	
Weight	
Ideal Weight	
Highest Adult Weight / Year	
Lowest Adult Weight / Year	

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? Do you wake frequently during the night?

Do you wake feeling rested? ◯ Yes ◯ No

How often do you exercise?

What types of exercise do you do?

What do you do to have fun?

Do you have any pets? ◯ Yes ◯ No

What level of stress are you currently experiencing?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

1 = Not much stress, 10 = An immense amount stress

List your main stressors

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

How many hours per day do you use a computer?

How many hours per day do you use a cell phone?

How many hours per day do you use watch TV?

Chemicals

Where did you grow up? ◯ City ◯ Country

City or country?

What type of environment do you/ have you worked in?

Do you smoke cigarettes or vape? ◯ Yes ◯ No

Have you had any dental work done?

Do you have fillings (metal), root canals, crowns, etc?

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

1 = Lowest, 10 = Highest