Enhance Nutrition, LLC
Marcy Kirshenbaum, MS, CCN, CNS, LDN
847.987.1128

Client Intake Form

Personal Information

Name: | Date:

Birthdate: | Age: | Gender:

Height: Weight:

Address: City: State: Zip:

If a minor, provide parent name(s):

Email:

Home Phone: Work Phone: Cell Phone:

Check box for preferred phone number to contact you

Employer/Occupation:

Ethnic background:

Relationship status: Married Single Divorced Widow/ Widower Other:

Emergency Contact Name & Phone number:

Do you have children? Y N Ages?

Do you have pets? Y N What type and how many?

Primary Care Physician name and phone:

How did you hear about me? Workshop/ Seminar Business Card Website

Referred by:

Health & Wellnes

Reason for visit?

Please list or attach any test results from a doctor such as blood, urine, etc.

What are your primary health and wellness concerns and/or goals?

Are there any obstacles or challenges that you believe make it difficult to achieve your health and wellness goals?

Have you previously utilized nutritional or lifestyle protocols to improve your health and wellness, and if so what were they and what were your results?

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Indicate below if you or an immediate family member have or had any of the following conditions:

Condition	Self	Family	Condition	Self	Family
Cardiovascular			*Muscular, Skeletal, Joints*		
High blood pressure			*Joint Pain, stiffness, swelling*		
Low blood pressure			*Frequent muscle cramps*		
High cholesterol			*Osteoarthritis*		
Heart attack or stroke			*Rheumatoid Arthritis*		
Arrhythmia			*Osteoporosis/Osteopenia*		
Digestive/ Gastrointestinal			*Endocrine*		
Acid reflux/heart burn/indigestion			*Diabetes Mellitus Type 1*		
Colitis			*Diabetes Mellitus Type 2*		
Hiatal hernia			*Hyperglycemia*		
Celiac disease			*Hypoglycemia*		
Irritable Bowel Disease, IBD			*Thyroid disorder*		
Irritable Bowel Syndrome, IBS			*Adrenal disorder*		
Genital/Urinary			*Liver/Gall Bladder*		
Frequent yeast infections			*Hepatitis*		
Urinary tract infections			*Cirrhosis*		
Kidney stones			*Gall stones*		
Kidney or bladder disease			*Viral/ Bacteria infections*		
Neurological/ Mental Status			*HIV/AIDS*		
Anxiety or Depression			*Sexually transmitted disease*		
Migraines			*Lyme disease or other tick-borne illness*		
Dementia/ Alzheimer's			*Frequent strep throat*		
Multiple Sclerosis (MS)			*Other Conditions*		
Parkinson's Disease			*Cancer, if so, type:*		
Fibromyalgia					
Respiratory/ Ear, Nose, Throat					
Sinusitis					
Ear infections/ tubes in ears			*Food allergies or sensitivities*		
Chronic obstructive pulmonary disease (COPD)			*Seasonal/environmental allergies*		
			Chemical sensitivity		
Chronic bronchitis			*Anemia/ blood condition*		
Asthma			*Alcohol or substance abuse*		
Emphysema			*Epilepsy or seizures*		
Frequent colds, infections			*Eating disorder*		
Menstrual			*Skin condition (eczema, dermatitis, psoriasis, acne)*		
Painful periods					
Irregular/ absent periods			*Obesity/ overweight*		
Heavy periods/ excessive bleeding			*Gout*		
Premenstrual syndrome (PMS)			*Chronic Fatigue syndrome*		
Endometriosis			*Female hair growth on face/ chest*		
			Dental/ periodontal problems		
Other not listed:					

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Mark the circle for each condition below signifying your level of severity from "0" being never to "5" being always.

	0 5		0 5
Constipation		*Cannot fall asleep*	
Diarrhea		*Cannot stay asleep*	
Pass large amounts of foul smelling gas		*Insomnia*	
Laxative use		*Slow starter in the morning*	
Excessive burping, gas or bloating		*Afternoon fatigue*	
Gas immediately after a meal		*Dizziness when standing up quickly*	
Sense of fullness during & after a meal		*Afternoon headaches*	
Nausea		*Perspire easily*	
Undigested food found in stool		*Under high amounts of stress*	
Heartburn when lying down or bending forward		*Weight gain when under stress*	
Antacid use		*Wake up tired even after 6 + hours of sleep*	
Specific foods cause heartburn		*Tired, sluggish*	
Greasy/high fat foods cause distress		*Feel cold – hands, feet, all over*	
Crave sweets during the day		*Gain weight easily*	
Irritable if meals are missed		*Thinning hair on scalp, face, genitals*	
Eating relieves fatigue		*Dry skin*	
Fatigue after meals		*Mentally sluggish*	
Eating sweets doesn't relieve sugar cravings		*Heart palpitations*	
Must have sweets after meals		*Nervousness/highly emotional*	
Crave salt		*Night sweats*	
Crave chocolate		*Difficulty gaining weight*	

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Women's Health

Regular periods? ☐ *Y* *N* *Age started:*

Date of last period:

Concerns?

Are you ☐*peri-menopausal* ☐*post-menopausal?*
If so, symptoms/ concerns?

Do you take birth control pills? ☐ *Y* *N*

Are you using ☐*bio-identical or* ☐*synthetic hormones?*

Men's Health

Do you have prostate issues/ concerns? ☐ *Y* *N*
Describe:

Do you have erectile concerns? ☐ *Y* *N*
Describe:

Treatments, Medications & Supplements

Are you currently being treated for a medical condition? ☐ *Y* ☐*N* *Condition(s)?*

List any prescription/OTC medications you are currently taking:

Vitamin, mineral or other supplements (e.g., probiotics, herbs, etc):

Allergies or sensitivities (food, drugs, seasonal, chemical, other):

Recent immunizations/vaccinations?	*When did you last take an oral antibiotic?*

Eating Habits & Food Intake

How many times per week do you eat out, or bring home take-out food?

Do you eat packaged or frozen foods? ☐ *Y* *N* *How often?*

Do you typically eat breakfast? *Y* *N*	*How many meals do you eat per day?*
How many times a day do you snack?	*Please provide examples of your typical snack:*
Do you drink alcohol? ☐ *Y* ☐*N* *Type & how much per day/ week?*	*Do you smoke cigarettes or cigars?* ☐ *Y* *N* *How many/day?*

What are the foods you eat most frequently in a given week?

Do you frequently feel thirsty? ☐ *Y* ☐ *N*	*What do you drink most in a given day?* *How much water do you drink?*
Do you often feel hungry? ☐ *Y* *N*	*Do you eat beyond feeling full?* *Y* *N*

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Reflect on what you think the "triggers" are to your eating outside of basic meals and snacks, (e.g. stress, fatigue, boredom, joy, nervousness).

Are there any foods will you NOT eat?

Indicate all that apply to your current state of being, lifestyle and eating habits	
Eat too much	*Love to eat*
Erratic eating patterns	*Frequent colds, illness*
Eat on the run, travel frequently	*Poor focus, memory, attention*
Emotional eating	*Do not plan meals or menus ahead*
Late night eating	*Rely on convenience/ fast foods*
Fast eater	*Often eat/ drink for business or social occasions*
Skip meals	*Confused about what to eat*

Lifestyle, Exercise, and Sleep	
Describe your typical daily energy level? *Low* ☐ *Average* *High*	
Do you engage in regular physical exercise? ☐ *Y* *N* *Type & frequency:*	*What is your current stress level?* ☐ *Low* ☐ *Average* ☐ *High*
Any physical conditions which limit your ability to exercise? ☐ *Y* ☐ *N* *Describe:*	*What causes you stress?*
How many hours do you sleep per night? *Do you wake feeling rested?* ☐ *Y* ☐ *N*	*What do you do to relieve stress?*
Is there anything else you would like to share?	

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Informed Consent

- *Nutrition and exercise are intended to promote general health and wellness and are not intended to replace. physician care or medical intervention. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input, and are not intended to diagnose, treat or cure any disease or ailment*
- *You accept all responsibility for reviewing diet, nutrition, lifestyle or exercise suggestions with a licensed medical professional before following said suggestions.*
- *Any activity or program may have inherent risks, which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself. You agree to inquire about any activities with which you are not familiar, and provide any information which may limit your participation in suggested activities.*
- *Results and changes in your general health and wellness may vary depending on medical conditions, medications, and accuracy in following suggested guidelines.*
- *As your general health and wellness may change with modifications in diet, nutrition and lifestyle, physician prescribed medications may require modification. It is your responsibility to discuss this with your physician. Never reduce or eliminate physician prescribed medications without the direction of your physician or medical care provider.*
- *Your personal and health information will remain confidential and will not be shared without your consent. You give permission for the information provided on this form and discussed in your nutritional consultation(s) to be shared and discussed with the primary care physician you have listed on this form, at the discretion of the nutritionist and in the interest of your general health and wellness.*
- *Marcy Kirshenbaum and Enhance Nutrition, LLC reserve the right to refuse services to any individual.*

Payment is due at the time of service.

Please call at least 24 hours ahead of time if you must cancel an appointment. There is a $75 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours notice.

The provision of services, work product, advice and the delivery of supplements may be suspended due to lack of payment. Returned check fee of $25.

Print Name: ______________________________

By signing below, you agree to the above terms and conditions for participation in nutritional consultation with Marcy Kirshenbaum and Enhance Nutrition, LLC.

Signature: ______________________ *Date:* __________