

# Kaleidoscope Wellness Intake Form

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_ Birthday \_\_\_\_\_

Relief from what top 3 symptoms (see back page) \_\_\_\_\_

Life Goals \_\_\_\_\_

How much sweaty activity weekly? \_\_\_\_\_ What type of activity? \_\_\_\_\_

How many ounces of water do you drink daily? \_\_\_\_\_ What type? RO Tap Spring Distilled Filtered

Which meals daily are eaten? **Breakfast Lunch Supper** How many eliminations per day? \_\_\_\_\_

How many digestive enzymes daily? \_\_\_\_\_ How many breathing exercises daily? \_\_\_\_\_

How much of the following do you consume? (example, 1D = once daily, 3M = 3 times monthly)

Soda Pop \_\_\_\_\_ Coffee \_\_\_\_\_ Smoking \_\_\_\_\_ Alcoholic Beverages \_\_\_\_\_

Fast Food \_\_\_\_\_ Milk \_\_\_\_\_ White Flour \_\_\_\_\_ Sugar Usage \_\_\_\_\_

Raw Fruit \_\_\_\_\_ Meat \_\_\_\_\_ Raw Veggies \_\_\_\_\_ Whole Grains \_\_\_\_\_

What types of food do you crave? **Salty Chocolate Sweets Breads Other** \_\_\_\_\_

What are your favorite foods? \_\_\_\_\_

How much daily energy (1 = lowest energy level; 10 = highest energy level) do you have? \_\_\_\_\_

What surgeries have you had and when? Circle NONE if applicable. \_\_\_\_\_

How many hours of TV do you watch? Daily \_\_\_\_\_ Weekly \_\_\_\_\_

How many hours of spiritual enrichment each week? (Bible, prayer, church, etc.) \_\_\_\_\_

How many hours a week do you spend with family/friends? \_\_\_\_\_

How many hours of sleep do you get each night? \_\_\_\_\_ How many hours do you need? \_\_\_\_\_

What kind of prescription medication do you take? Circle NONE if applicable. \_\_\_\_\_

What is your Blood Type:  A  B  AB  O  Positive  Negative

Who referred you for your appointment today? \_\_\_\_\_

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and this is a personal ministry and spiritual counseling.

I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health and do not involve the diagnosing, treatment, or prescribing of remedies for disease.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Kaleidoscope Wellness Intake Form

Mark X for Current & O for Past

	Acne		Cancer		Emphysema		Insomnia		Polyps
	ADD/ADHD		Candida: Yeast Infections		Epilepsy		Joint Pain		Pregnancy
	Adrenal Glands		Canker Sores		Eyes		Kidney Issues		Prostate
	Allergies		Carpal Tunnel		Fatigue		Kidney Stones		Psoriasis
	Alzheimer's Disease		Cataracts		Fever		Laryngitis		Rash
	Anemia		Chest Congestion		Flu		Leprosy		Reproductive
	Anger		Chest pain		Gallstones		Leukemia		Respiratory
	Anxiety		Cholesterol		Gangrene		Liver		Rheumatism
	Appetite		Circulation		Gas		Lung Issues		Ringworm
	Arteriosclerosis		Cold - Common		Gout		Lupus		Seizures
	Arthritis		Cold - Temperature		Gums		Lymph Glands		Shingles
	Asthma		Colic		Hair Issues		Menopause		Sinus
	Back Pain		Colon		Heartburn		Menstrual Cramps		Skin Issues
	Bad Breath		Constipation		Hemorrhoids		Migraines		Snoring
	Bed Wetting		Cough		Herpes		Mono		Sore Throat
	Bell's Palsy		Cravings		Hiatal Hernia		Mucous		Stomach
	Bites		Dandruff		Hives		Nails		Stress
	Bladder		Depression		Hormones		Nausea		Stroke
	Blood Pressure High Low		Diabetes Type 1 or 2		Hyperactive		Nervousness		Sty
	Boils		Diarrhea		Hypertension		Nose Bleeds		Teeth
	Bones		Digestion		Hyper / Hypo thyroidism		Parasites		Tonsillitis
	Breathing		Dizzy Spells		Hypoglycemia		Parkinson's Disease		Ulcers
	Bronchitis		Ear Infection		Impotence		Perspiration		UTI
	Bruises		Ear Ringing		Incontinence		PMS		Vertigo
	Burns		Edema		Indigestion		Pneumonia		Weight

Other:

Notes: