Health Intake Form

Leanne Harris / Whole Food Works

Name and Date _____

1) Why are you seeking help now?

_____

_____

2) What goals would you like to set for your health? (Is this more of a quick fix for you or lifestyle change?)

_____

_____

3) What all have you tried that has not worked for you?

_____

_____

4) Are you under unusual stress?

_____

_____

5) What diagnoses have you been given?

_____

_____

6) Do you have allergies to food or medicine?

_____

_____

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7) Do you take medications? For what?

_____

_____

8) Rate your current health habits with 10 being the absolute best and 0 being totally nonexistent.

_____ Your water intake (one half of your body weight in ounces everyday)
_____ Your sleep quality and time (no waking, solid 8 hours)
_____ Your exercise and movement (30 mins daily)
_____ Your gratitude practice
(reading, using affirmations, meditation and prayer, positive community)
_____ Your fruit and vegetable intake
(a variety of at least 7 servings a day. A serving is the size of your fist)
_____ Your food quality (large variety, mostly organic, mostly raw – explain below)

_____

_____

9) What time do you eat your meals and do you snack in between?

_____

_____

10) Do you eat food products with dairy? Please list.

_____

_____

11) Do you eat food products with wheat/gluten? Please list.

_____

_____

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12) Do you have a problem with sugar cravings? Please list.

_____

_____

13) Do you consume products with food dyes? Please list.

_____

_____

14) Do you take vitamin supplements? Please list.

_____

_____

15) Do you like to meal plan and shop for food?

_____

_____

16) Do you like to prepare meals?

_____

_____

17) Are you interested in learning to shop differently? YES / NO

18) Are you interested in learning to make dishes that support your health goals? YES / NO

19) Do you have trouble sticking with a plan? YES / NO

20) Who do you need support from to be successful?

_____

_____