CLIENT INTAKE FORM (CHILD)

ABOUT YOU

Today's Date ___/___/___ Your First Name________________ You Like to be Called_____________M.I.___

Last Name__________________________________ Age _____ Gender_M / F_ Birthdate _____/_____/____

Address____________________________________ City __________________ State ___ Zip ____________

Primary Phone (_____)_______________type_____ Second Phone (_____)_________________type______

Email Address (no spam *ever* :-) ____

Referred By ____

ABOUT THE CHILD

First Name________________M.I.___Last Name___________________Age ___Birthdate _____/_____/____

Height ________ Weight ________ Blood Type: ____ Water Type (Well or City)________

Daily Intake… Water: ___glasses Caffeine: ___cups Artificial Sweeteners: ___packets Cigarettes: ___packs

Soda Pop: ____cans daily / weekly diet / regular Alcohol: ____drinks daily / weekly beer / wine / liquor

Recreational Drugs (your responses are held in strict confidentiality): ________________________________

Prescription Drugs ____

____

Nutritional Products/Vitamins ____

____

Known food allergies or sensitivities____

Sleep patterns:____

Bowel Movements: ___times daily / weekly_ Diarrhea? _yes / no_ Constipation? _yes / no_

Top 3 Health Goals ____

Top 3 complaints, illnesses, or sicknesses ____

Does he/she see a physician? _yes / no_ Physician's name _______________________________________

Does he/she see a chiropractor? _yes / no_ Chiropractor's name ___________________________________

How does he/she relieve stress? ____

HOW IS YOUR CHILD'S

Daily Energy Level?	Excellent	Good	Fair	Poor
Handling of Daily Stress Level?	Excellent	Good	Fair	Poor
Support System of Family & Friends?	Excellent	Good	Fair	Poor
Overall Enjoyment of Life?	Excellent	Good	Fair	Poor

NUTRITION & EXERCISE HABITS

How many meals does he/she eat each day?___ Does he/she skip meals? _yes / no_ ___times daily/weekly

Does he/she eat out? _yes / no_ ___times daily/weekly Typical Cuisine ________________________________

Typical Breakfast ____ Lunch ___________________________

____________________ Dinner ____ Snacks __________

____________________________________ Food cravings: salty / sweets / fats / carbs other ______________

Exercise: ____times daily / weekly types of exercise ____

Describe his/her daily activity level (outside of exercise) ____

PAST WELLNESS

Childhood Illnesses____

Childhood Viruses: cold sores / mono / acne other____

Has he/she ever been in a car accident? yes / no year______ injuries___________________________________

When did he/she last have blood-work done? ____

Surgeries ____

Family History of Diseases (type and relationship) ____

____

Grandma Living? _yes / no_ age____ cause of death ____

Grandpa Living? _yes / no_ age____ cause of death ____

GIRLS ONLY

At what age did she begin menstruation? __________ When was her last period? ______________________

Describe her menstrual cycle ____

Has she ever used Birth Control? _yes / no / now_

Check all that apply:

- ☐ PMS
- ☐ Pregnant
- ☐ Nursing
- ☐ No Periods
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Painful Intercourse
- ☐ Bladder Issues
- ☐ Frequent Urination
- ☐ Burning Urination
- ☐ Vaginal Yeast Infections
- ☐ Urinary Tract Infections

BOYS ONLY Check all that apply:

- ☐ Frequent Urination
- ☐ Burning Urination
- ☐ Slow Urination / Dribbling
- ☐ Difficulty with Erection

CIRCLE "C" –or– "P" FOR EVERYTHING THAT APPLIES: *"C" = Current, "P" = Past*

Cardiovascular
C P – Heart Disease
C P – High Blood Pressure
C P – Low Blood Pressure
C P – Heart Attack
C P – Stroke
C P – High Total Cholesterol Level
C P – High LDL-Cholesterol Level
C P – Low LDL-Cholesterol Level
C P – High Triglycerides
C P – Fainting
Other: ________________________

Hepatic / Liver
C P – Hepatitis A / B / C
C P – Fatty Liver
C P – Anemia (low Iron)
C P – Chemical Sensitivities
Other: ________________________

Neurological
C P – Severe Mood Swings
C P – Chronic Depression
C P – Suicidal Tendencies
C P – Addiction (alcohol, drugs, ______)
C P – Panic Attacks
C P – Seizures
C P – Anxiety or Nervousness
C P – Memory Loss or Confusion
C P – ADD / ADHD
C P – Autism
C P – Dyslexia
C P – Bipolar
C P – Learning Disabilities
C P – Schizophrenia
C P – Insomnia
C P – Headaches: cluster / migraine / sinus
C P – Tinnitus (ringing in the ears)
C P – Tourette Syndrome
C P – Eating Disorder _____________
Other: ________________________

Muscle, Bone & Joint
C P – Arthritis osteo / rheumatoid
C P – Osteoporosis or Osteopaenia
C P – Exercise Limitations
C P – Chronic Pain muscles / joints
Other: ________________________

Immunology
C P – Frequent Colds or Flu
C P – Cancer: __________________
C P – Chronic fatigue
C P – Upper Respiratory Allergies
C P – Systemic Yeast Infection
C P – Recurring Ear Infections
C P – High Levels of Inflammation
C P – Auto-immune Disease
Other: ________________________

Sexual Health
C P – Herpes Simplex II (genital)
C P – HIV
C P – STDs ____________________
Other: ________________________

Endocrinology
C P – Thyroid Condition
C P – Hypothyroidism
C P – Hyperthyroidism
C P – Graves' Disease
C P – Hashimoto's Disease
C P – Goiter
C P – Poor Hair / Nail Growth
Other: ________________________

Urinary / Renal
C P – Kidney Stones
C P – Bladder Infections / Cystitis
C P – Gout
Other: ________________________

Metabolic
C P – Diabetes Type I / Type II
C P – Difficulty Losing Weight
C P – Difficulty Gaining Weight
C P – Overweight
C P – Metabolic Syndrome
C P – Hypoglycemia
Other: ________________________

Dermatology
C P – Hives
C P – Rosacea
C P – Acne
C P – Psoriasis
C P – Dandruff
C P – Eczema
C P – Rashes
Other: ______________________

Dental
C P – Bleeding Gums
C P – Teeth Fillings / Crowns
C P – Excessive Cavities
C P – Enamel Disorders
C P – Porous Teeth
Other: ______________________

Gastrointestinal
C P – Ulcers
C P – Diarrhea
C P – Constipation
C P – Indigestion
C P – Hemorrhoids
C P – Bloating / Gas
C P – Hernia: inguinal / hiatus
C P – Colon Polyps
C P – Acid Reflux / Heartburn
C P – Crohn's Disease
C P – Ulcerative Colitis
C P – Diverticulosis / Diverticulitis
C P – Irritable Bowel Syndrome
C P – Parasites
C P – Candida
Other: ______________________

Vision
C P – Macular Degeneration
C P – Poor Night Vision
C P – Cataract
C P – Glaucoma
C P – Conjunctivitis (pink eye)
Other: ______________________

Respiratory
C P – Bronchitis
C P – Asthma
C P – Emphysema
C P – Sinus Infections / Polyps
C P – Pulmonary Disease
C P – Airborne Allergies
Other: ______________________

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ANS CANCELLATION POLICY

Last-minute cancellations deny other clients' timely access to their health practitioner. By requesting our clients agree to a cancellation fee, it reduces the number of cancellations and cuts down on your waiting room time.

✯ There is **NO CHARGE** if you cancel within **3** days of your appointment date.

- **3 days or more**: no charge
- **24-72 hours:** $25
- **24 hours or less, no-show, no-call:** $30
- **Saturday appointments no-show, no-call or cancelled within 24 hours:** **Will result in a full office visit charge***
  (**they are the most in-demand day and we usually have a wait list*)

✯ To assist you, ANS will provide you **one** *Courtesy Reminder,* **5-7 days** before your appointment. **Our reminder phone calls/emails are a courtesy to you. You are responsible for your appointment dates.** Note: appointments are considered confirmed when scheduled, therefore, in the unlikely event of not receiving *a Courtesy Reminder,* the fee still stands**.**

✯ You may call anytime to cancel. If you leave a message, be sure to leave your phone number, reason for cancellation, and the best time for us to call you back to reschedule. We can use the 'timestamp' of the voicemail to validate the time of your phone cancellation. You may also email **info@whysuffer.net** to cancel, or send text to our text-only phone number: 248-321-6649

✯ ANS reserves the right to waive fees or honor charges at its sole discretion.

Your Preferences:

How do you prefer to receive your Courtesy Reminders?
Email ___________________ **Phone Call/Voicemail** ____-____-_____ **Text** ____-____-_____

If a fee is assessed, you authorize Advanced Nutritional Solutions to charge your credit/debit card on file. If your card is declined, you are still responsible for the charge.

I agree to these terms and conditions (***Please Sign***):

____ ___________________
Client Signature Date

____ ___________________
Print name as it appears on Debit/Credit Card: Billing Zip Code

Debit/Credit Card#__________________________________ Exp___/_____ CVV_____