COOPER HEALTH SOLUTIONS

HEALTH PARTICIPATION
CLIENT INTAKE FORM
(Please Print)

Today's date:

CLIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid			
Are you a previous client? ❑ Yes ❑ No	Preferred appointment day/time?	(Former name):	Birth date: / /	Age:	Gender: ❑ M ❑ F			
Street address:		Cell phone: ( )	Home phone: ( )					
P.O. box:	City:	State:	ZIP Code:					
Occupation:	❑ Sedentary ❑ Moderately active ❑ Mildly active ❑ Highly active	Employer:						
Chose us because/Referred to us by (please check one box): ❑ Dr. _____ ❑ Other practitioner _____ ❑ Family ❑ Friend ❑ Website ❑ Social Media ❑ Other (please specify) _____								
Other family members seen here:								

REASON FOR VISIT/GOALS

What would you like to achieve? (Health, Wellness, Fitness, Weight/Body Composition)
(Please provide a specific and prioritized list)

1.

2.

3.

4.

5.

How will reaching these goals impact your life? Why is it important to you?

Readiness for change and commitment to your goals:	Please rate yourself with 1 the least and 10 the highest									
Commitment to achieving your goals	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Confidence for success	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Priority in your life	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Support system	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Who is supporting you? (Please list family, friends or other)

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WELLNESS HISTORY

Basic Measurements

Height		Weight (lbs)		Body Fat %	

Activity

Do you exercise or do any fun sweaty activity? ❑ Yes ❑ No	Frequency? ❑ Daily ❑ 1-2x/wk ❑ 3-4x/wk ❑ 5-7x/wk
If no, does anything prevent you?	

What type?	Method:	How many hours per week?
❑ Strength/Resistance	❑ Total Body ❑ Splits ❑ Cross Fit style ❑Other _____	
❑ Cardiovascular	❑ Run/Jog ❑ Bike ❑ Elliptical ❑ Walk ❑ Other _____	
❑ Yoga / Pilates	❑ Hot ❑ Restorative ❑ Reformer ❑ Mat ❑ Other _____	
❑ Other (please specify)		

Sleep & Stress

What time do you go to bed? am/pm	What time do you wake up? am/pm	How many hours?
How long does it take you to fall asleep? ❑ Fall right to sleep (under 15 minutes) ❑ _____ minutes		
Do you use anything to fall asleep? ❑ Read ❑ TV ❑ Screen time ❑ Meditation/Music/White Noise ❑ Meds/Supplements (below)		
How many times do you wake at night?	Please specify any meds or supplements to aid sleep:	
Do you fall right back to sleep? ❑ Yes ❑ No		

Morning energy (10 is highest)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Afternoon energy (10 is highest)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Evening energy (10 is highest)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Stress level (10 is worst)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Stressors:
How do you manage your stress?

Nutrition

Do you follow any special diet? (Mediterranean, Kosher, Gluten free, vegetarian, intermittent fasting etc.)		❑ Yes	❑ No
Please specify:			
Do you follow this diet for religious or moral beliefs?		❑ Yes	❑ No
Are you willing to consider changing this diet?		❑ Yes	❑ No
How often do you eat out per week?	Where?		
How much water do you consume daily (in ounces)?			
Type of water? (circle all that apply) Tap / Filtered / Reverse Osmosis / Alkaline / Bottled / Spring / Distilled			
How much coffee do you consume daily (in ounces)?	Caffeinated	❑ Yes	❑ No
How much soda do you consume daily (in ounces)?	Caffeinated	❑ Yes	❑ No

Alcohol consumption?	Number of drinks per week:	Type?
Do you do the cooking? ❑ Yes ❑ No	Do you like to cook? ❑ Yes ❑ No	
Do you do the shopping? ❑ Yes ❑ No	Where do you shop for food?	
Do you have cravings? ❑ Yes ❑ No	Do you eat out of emotions? (stress, depression, boredom, etc.) ❑ Yes ❑ No	
What type of cravings? ❑ Sugar ❑ Salt ❑ Starch	Specify craving and time of day:	

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Typical day of eating			
Meal	Time of Day	Location (home prepared or out)	Type of food or drink and quantity
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Supplementation							
Supplement / Brand / Serving	Time of Day	With meal?		Supplement / Brand / Serving	Time of Day	With meal?	
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No

Health History		
Do you smoke? ❑ Yes ❑ No	Have you ever smoked? ❑ Yes ❑ No	How long ago? years months
Do you experience gassiness or bloating after meals or at any other time? ❑ Yes ❑ No		When?
What foods?		
Do you have daily bowels movements? ❑ Yes ❑ No	How many per day?	Consistency? Firm / Loose / Greasy / Pebbles
Please list any injuries and when:		
Please list any surgeries and when:		

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Women's Health					
Menstrual cycle? ❑ Yes ❑ No	❑ Normal ❑ Irregular	❑ Normal flow	❑ Heavy flow	❑ Light flow	
Days between periods?	Date of last period?	❑ Perimenopausal	❑ Menopausal	❑ Postmenopausal	
Pregnant? ❑ Yes ❑ No	If yes, due date?	Did you have an operation that stopped your period? ❑ Yes ❑ No			
Breast feeding? ❑ Yes ❑ No					

Symptoms, Medical Diagnoses (by a licensed medical practitioner) and/or Areas of Concern:

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

Allergies:

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Food Sensitivities:

Environmental/Chemical Sensitivities:

Medications (prescription and OTC)					
Medication	Dose	How long?	Medication	Dose	How long?
		years months			years months
		years months			years months
		years months			years months
		years months			years months
		years months			years months

Anything else you would like me to know?

IN CASE OF EMERGENCY			
Name:	Relationship:	Home phone: ( )	Work phone: ( )

CLIENT ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I understand that I am here to learn about nutrition and better health practices, 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 purpose 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.

Client/Guardian signature *Date*