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				
E-mail address:		Preferred method of contact: ❑ Home phone ❑ Cell phone ❑ Text message ❑ E-mail							
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:		

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

OTHER:

Allergies:

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?

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TRUE CELLULAR DETOX™ NEUROTOXIC QUESTIONNAIRE

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

POINT SCALE:

0 = Never had symptom, 1 = Occasionally have it, mild effect, 2 = Occasionally have it, severe effect, 3 = Frequently have it, mild effect, 4 = Frequently have it, severe effect

Section 1	Not Severe				Very Severe
Anxiety	0	1	2	3	4
Mood swings	0	1	2	3	4
Enraged behavior or anger	0	1	2	3	4
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3	4
Irritability (not typical to your personality)	0	1	2	3	4
Low body temperature (below 97.3 F)	0	1	2	3	4
Insomnia (can't get to sleep or return to sleep)	0	1	2	3	4
Dizziness	0	1	2	3	4
Sound in ears (ringing or hearing your heart beat)	0	1	2	3	4
Psychological symptoms, even thoughts of suicide	0	1	2	3	4
Sensitivity to sound	0	1	2	3	4
Section 1 total: _____					

Section 2	Not Severe				Very Severe
Indecisiveness	0	1	2	3	4
Feeling of being overwhelmed or fearful	0	1	2	3	4
Metallic taste in your mouth	0	1	2	3	4
Bad breath	0	1	2	3	4
Bleeding gums	0	1	2	3	4
Sensitive teeth	0	1	2	3	4
Canker sores or other sores in the mouth	0	1	2	3	4
Floaters, shadows or swimmers when you read or look into the sky	0	1	2	3	4
Dyslexia or loss of place while reading, even as a child	0	1	2	3	4
Swelling eyelids	0	1	2	3	4
Peeling on the top layer of skin (hands, feet)	0	1	2	3	4
Dry skin	0	1	2	3	4
Heart pain (angina) and you are under 45 years old	0	1	2	3	4
Depression	0	1	2	3	4
Gout (arthritic pain, especially in big toes)	0	1	2	3	4
Pain in shoulders or upper back	0	1	2	3	4
Twitching eyelids	0	1	2	3	4
Anemia	0	1	2	3	4
Wrist/ankle drop or weak extensor muscles	0	1	2	3	4
Hair falls out (not normal male pattern baldness)	0	1	2	3	4
Section 2 total: _____					

Section 3	Not Severe				Very Severe
Sensitivity to light	0	1	2	3	4
Fatigue after exercising (feeling worse)	0	1	2	3	4
Bad night vision or seeing halos around lights	0	1	2	3	4
Shortness of breath, with very little effort	0	1	2	3	4
Excessive thirst and/or frequent urination	0	1	2	3	4
Red eyes or tearing	0	1	2	3	4
Blurred vision at times	0	1	2	3	4
Morning stiffness	0	1	2	3	4
Sensitivity to smells (chemicals such as petrochemicals, perfumes, air fresheners)	0	1	2	3	4
Chronic fatigue or weakness	0	1	2	3	4
Non-restful sleep	0	1	2	3	4
Section 3 total: _____					

Section 4	Not Severe				Very Severe
Receive static shock more often & with more dramatic effect than normal	0	1	2	3	4
Trouble processing new information	0	1	2	3	4
Word reversal or trouble finding words	0	1	2	3	4
Sensitivity to touch	0	1	2	3	4
Short-term memory loss	0	1	2	3	4
Chronic sinus congestion	0	1	2	3	4
Dry non-productive cough	0	1	2	3	4
Muscle twitching	0	1	2	3	4
Excessive sweating, especially at night	0	1	2	3	4
Joint pain - not necessarily true arthritis - can move from joint to joint	0	1	2	3	4
Difficulty losing weight regardless of diet or exercise	0	1	2	3	4
Persistent fungal or viral infection, including athlete's foot, warts, jock itch, candida	0	1	2	3	4
Frequent illness, prolonged illness or sick days	0	1	2	3	4
Numbness or weakness in arms and legs	0	1	2	3	4
Headaches	0	1	2	3	4
Trouble adding or dividing numbers in your head	0	1	2	3	4
Fluctuating constipation and diarrhea	0	1	2	3	4
Stomach pain for no apparent reason	0	1	2	3	4
Appetite swings	0	1	2	3	4
Frequent muscle aches, cramps, unusual sharp sudden pains	0	1	2	3	4
Rashes or rosacea	0	1	2	3	4
Cold extremities (hands and feet)	0	1	2	3	4
Section 4 total: _____					

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TRUE CELLULAR DETOX™ NEUROTOXIC QUESTIONNAIRE

POINT SCALE TOTAL: _____

Scoring over 100: Severely neurotoxic; this patient is positive for neurotoxicity and undoubtedly needs TCD and will need to complete many brain phases to detox.

Scoring: 50-100: Moderate neurotoxicity; this patient is positive for neurotoxicity and needs TCD to decrease symptoms and improve overall health.

Less than 50: less toxic; this patient should still do TCD to increase vitality due to the ubiquitous neurotoxins in our modern world.

Remember, the most important part is to observe whether the patient is improving or not, returning to the initial health goals at each appointment, along with retaking the other tests (meta-oxy, VCS) every 30 days as well. Don't get too caught up in the specific symptomology but look at the trends and observe their overall detox progress results.

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. These statements have not been evaluated by the Food and Drug Administration. These products are not intended to diagnose, treat, cure, or prevent any disease.

_____ _____

Client/Guardian signature *Date*