NEW CLIENT INTAKE FORM

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HEALTH CONCERNS/SYMPTOMS	
Describe your main concerns (symptoms, diagnosis, onset, duration, treatment)	
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What are you hoping to learn/understand/accomplish with our guidance and expertise?	
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Would you like us to coordinate care with your team of health care providers?	
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DIETARY SUPPLEMENT and MEDICATION LOG

If you currently take dietary supplements or medications, please fill out the following table and bring it to your next appointment.

Supplement / Medication Name	Brand Name	Dose (how much, how often)	Purpose of supplement / medication	Who prescribed? (self, practitioner)