GENOMIC WELLNESS of Beverly Hills

NEW CLIENT INTAKE FORM

Beverly Hills Seattle Houston Chicago New York Miami

Patient Information

First Name: _____ Last Name: _____ Middle Name: _____
Preferred Name: _____ Preferred Pronoun: _____ Birthdate: ____/____/____ Age: _____
Gender Identity: M / F / NB / Trans Experience: _____Marital Status: S / M / D / W / Partnered / Separated
How Would You Like To be Contacted: Home Phone / Cell Phone / Work Phone / Email / Text / Facebook Messenger / Text
Address: _____ Apt / Unit: _____ City: _____ State: ____ Zip: _____
Cell / Home Phone: _____ Work Phone: _____ Email: _____

Intake Information

Who may we thank for referring you to our clinic? _____
What brings you in today? ☐ Health Condition ☐ Wellness ☐ Sustainable Weight Loss ☐ Nutritional Consult

Chief Concern that brings you in today and a brief description of your health journey thus far:

Our first goal is to get a complete clinical picture and comprehensive understanding of EVERTYTHING that is going on with your health, so please take some time to answer the following questions. We are mostly interested in the patterns over the last 6 months to a year.

In General, how would you rate the following? *(Circle all that apply)*

Mood	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse
Energy	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse
Happiness / Peace of Mind	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse
Sleep	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse
Nutrition	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse
Physical Activity	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse
Stress Level	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse
Libido / Hormone Balance	(bad) 1 2 3 4 5 6 7 8 9 10 (best) In the last month has it: Improved Stayed the same Gotten worse

Tell me about your tobacco use. *(Circle all that apply)*

Tobacco use	Y / N / Rarely/ Socially / In The Past / Over 10 Years Ago / Trying To Quit: Y / N
Tobacco type	Cigarettes Cigars Cigarillos Dipping / Chewing / Snuff Pipe Vape eCig
Years of use	1-3 4-6 6-10 11-20 21-30 Over 30 / Just Started Recently / Off & On
Amount per day	Less than 5 1/2 pack pack pack and 1/2 2 packs More than 2 packs

Tell me about your drug use. *(Circle all that apply)*

Drug use	Y / N / Rarely/ Socially / In The Past / Over 10 Years Ago / Trying To Quit: Y / N
Drug type	Marijuana Heroin Cocaine Ecstasy (Molly) Meth Barbiturates Solvents Benzos LSD Opium Shrooms Prescription Med Abuse
Years of use	1-3 4-6 6-10 11-20 21-30 Over 30 / Just Started Recently / Off & On

Tell me about your daily fluid intake. *(Circle all that apply)*

Water intake in ounces per day	Do You Drink Enough Water? Y / N How Much Do You Consume On Daily Basis 8 16 32 48 56 64 96 more
Type of water	Tap Reverse Osmosis (RO) Spring Mineral Filtered Soft Distilled Well Bottled-plastic Bottled (Glass / Metal) De-ionized Alkaline Water
Alcohol intake	None Rare Occasionally 8oz 16oz 32oz 48oz 56oz 64oz 96oz more Recovering To excess Would like to quit Sober
Type of alcohol	Beer Wine (red / white / sweet) Hard liquor Mixed drinks Low alcohol Alcohol free
How do you feel when you drink	Nothing Drunk easily Hung over easily Pleasant Angry Sleepy
Tea intake	None Occasional 1cup 2cups 3cups 4cups 5cups 6cups 1pot more
Tea type	Green Black Oolong White Pu-erh Flavored Herbal Iced Sweet Decaffeinated
Coffee intake	None Occasional 1cup 2cups 3cups 4cups 5cups 6cups 1pot more
Coffee type	Caffeinated Decaffeinated Espresso Iced Canned Cappuccino Latte Mocha
Coffee consumption	Morning Mid-day Evening Late night Do you NEED Coffee? Y / N
Soda intake	None 8oz 16oz 32oz 48oz 56oz 64oz 96oz more
Soda type	Diet Regular Caffeine Free
Soda consumption	Morning Mid-day Evening Late night Do you NEED Soda? Y / N
Energy drink intake	None 8oz 16oz 32oz 48oz 56oz 64oz 96oz more
Drink type	Red bull Monster Full throttle NOS MD Energy MD MDX Pepsi Maxx Rockstar Sobe Adrenaline Vault Other: _____
Drink consumption	Morning Mid-day Evening Late night Do you NEED Energy Drinks? Y / N
Dairy intake	None 8oz 16oz 32oz 48oz 56oz 64oz 96oz more
Dairy type	Raw Pasteurized Cow Goat Sheep Yak Buffalo Whole Low fat Skim 2% 1% Lactose free
Alternative milk	Almond Coconut Hemp Soy Rice Oat Hazelnut
Juice intake	None 8oz 16oz 32oz 48oz 56oz 64oz 96oz more
Juice type	Apple Orange Cherry Grape Grapefruit Pomegranate Carrot Tomato Acai Wheatgrass Greens Vegetable Other

Tell me about your food habits. *(Circle all that apply)*

Eating style	Omnivore (can eat anything) Vegetarian Vegan Macrobiotic Ovo-lacto Vegetarian Raw Vegan Fruitarian Semi-Vegetarian Kosher
Are you currently dieting?	Yes No
Type of diet	Low glycemic Low carb Low fat High protein Low calorie Very low calorie (500 calories) Akins South beach Keto Paleo Other
Food cravings	Chocolate Sweets Alcohol Soda Salty foods Tobacco Fatty food Ice cream Dairy Fried foods Breads Carbs

Fast food meals a week	None 1 2 3 4 5 6 7 8 9 10 10-15 16-21
Processed meat intake	Hamburgers Hot dogs Sausage Nuggets Fish sticks Bacon Lunch meat Salami Jerky Smoked meats Ham Bologna Potted Meat Other: _____
Other processed foods	Cereals Mac-n-cheese canned dinners microwave dinners boxed meals
Fish intake	Wild caught Farmed raised Canned Salmon Tuna Halibut Perch Trout Pollock Flounder Sardines Mackeral Tilapia Mahi Mahi Sushi Catfish Other lake fish Frozen battered Deep fried Grilled Baked Raw Broiled
Seafood intake	Wild caught Farmed raised Crabs Shrimp Squid Clams Oysters Crawfish Lobster Scallops
Meat intake	Beef Fish Chicken Lamb Organ Buffalo Goat Venison Elk Ostrich Other
Special meat considerations	Grass fed Grass finished Free range Natural Antibiotic free Wild caught Organic Farmed raised Cage free Pasture raised
Home cooked meals per week	None 1 2 3 4 5 6 7 8 9 10 10-15 16-21
Cooking oils	Margarine Lard Butter Olive Corn Coconut Canola Soybean Avocado Mustard Palm Peanut Rice Safflower Sesame DAG Ghee Walnut Almond Grape seed Sunflower Shortening Crisco Ghee
Dairy products	Milk Ice cream Butter Kefir Buttermilk Cheese Cottage cheese Yogurt
Sweets	Candy Cookies Cake Pie Gum Pastries Donuts Deserts Candy bars
Vegetable intake per day (handfuls)	None 1 2 3 4 5 6 7 8 9 10 10-15 More
Vegetable type	Broccoli Cauliflower Cabbage Carrots Dark leafy greens Potatoes Sweet potatoes Yams Asparagus Onions Brussels sprouts Beets Corn Celery Radish Turnips
Fruit intake per day (handfuls)	None 1 2 3 4 5 6 7 8 9 10 10-15 More
Fruit type	Tomato Bell peppers Squash Oranges Apples Bananas Kiwi Grapes Egg plant Prunes Raisins Plums Cherries Pineapple Avocado Pear Dates Figs Lemons Limes Nectarine Watermelon Peach Olives Melons
Berry type	Strawberries Blueberries Logan berries Raspberries Blackberries Currants Elderberry Cranberries Mulberries
Nut type	Almonds Brazil Cashew Chestnut Walnut Macadamia Pecan Pistachio
Seed type	Flax Chia Salba Pine Pumpkin Sesame Sunflower
Legume type	Peanut Black beans Black eyed Adzuki Fava Edamame Chickpea Garbanzo Kidney Lima Mung Navy Refried Pinto Soy Split pea Peas Green beans Pigeon pea Black eyed peas Other: _____
Grain type	Gluten free White Wheat Whole grain Whole wheat Amaranth Barley Buckwheat Millet Oat Steel cut oats Brown rice Rice Rye Spelt Ezekiel Triticale Semolina Bulgar Bean Bulgur Corn Montina Quinoa Sorghum Teff Karmut Farro Duram
Salad dressing type	Oil / vinegar Vinegar Ranch Blue cheese French Italian Honey Dijon Russian Thousand island Other: _____
Fried food intake	Yes No Rarely Some A lot
Natural sweetener type	Sugar Raw sugar Brown sugar Stevia Truvia Agave Syrups Molasses Rapadura Turbinato Sucanat Cane juice Xylitol Fructose Honey
Artificial sweetener type	Saccharin Sweet N Low Nutrasweet Aspartame Sucrolose Acesulfame Neotame
Health / food complications	Always hungry Never hungry Anorexia Bulemia Binge eater Decreased taste Always thirsty Sweet tooth Stress eating
Known food allergies?	Yes No Not sure
What foods are at issue?	Milk Wheat Eggs Nuts Fish Shellfish Soy Peanuts Other
Have you have had testing?	Yes No Blood Skin IgG IgE Not sure
How do you feel after eating	Acid reflux Bloating Gas Heart burn Stomach pain Nausea Vomiting Upset stomach Excessive fullness Sleepy Bitter taste Racing pulse

Do supplements upset your stomach?	Yes No Multi-vitamins Vitamin B Vitamin C Vitamin E Iron Minerals Herbals Other
Do you skip meals?	Yes No Breakfast Lunch Dinner
Do you feel better if you skip meals?	Yes No
Do you skip meals on a regular basis?	Yes No Breakfast Lunch Dinner
Do you feel better if you don't eat?	Yes No
Do you feel better or worse if you skip meals?	Better Worse No Different

Tell me about your day. *(Circle all that apply)*

Exercise type	Sports Weights Walking Jogging Running Pilates Swimming Resistance Calisthenics Other
Exercise duration	Daily Few days a week Weekly 10 minutes 15 minutes 30 minutes 45 minutes 1 hour over 1 hour
Stressors	Social Health Work Family Financial
Recent stressors	Death of spouse Divorce Separation Jail term Illness/injury Marriage Job change Job loss Pregnancy Retirement Financial change
Do you like your job?	Yes No Sometimes
What type of work do you do?	
Number of hours per week?	Retired Temporary Part time Full time 10 20 30 40 50 60 70 80+
Sleep habits	Well rested Not well rested Early to bed Late nighter Shift work Morning person Not a morning person Hard to fall asleep Hard to stay asleep Hard to wake
Sleep hours per night	3 4 5 6 7 8 9 10 11 12 13+
Bowel habits	Normal Constipated Diarrhea Alternating Constipation / Diarrhea
Bowel consistency	Normal Soft Hard Loose Watery Brown Black Pale Green Blood Oily Really smelly Mucous
Bowel movements per day	Per day (1 2 3 4 5) or Per week (1 2 3 4 5 6 7+)
Do you grind your teeth?	Yes No When awake When Asleep When Stressed

Tell me about your tummy. *(Circle all that apply)*

Do you have irritable bowel disease?	Yes No History of Mild Moderate Severe Unrelenting
Do you have Crohn's disease?	Yes No History of Mild Moderate Severe Unrelenting
Do you have ulcerated colitis?	Yes No History of Mild Moderate Severe Unrelenting
Do you have appenditis?	Yes No History of Mild Moderate Severe Unrelenting Multible Removed
Do you have diverticulitis?	Yes No History of Mild Moderate Severe Unrelenting Multiple Removed
Do you have gall bladder attacks?	Yes No History of Mild Moderate Severe Unrelenting Stones Gall Bladder Removed Gall Stones Removed
Do you have polyps in your colon?	Yes No History of Mild Moderate Severe Unrelenting Multiple Removed
How is your tongue?	Normal Bright Red Pale Purple Raised Red Spots Dry White Coat Split / Cracked Puffy Swollen Teeth Dents on Side
Any of these concerns?	Anal Itching History of Parasites
Do you have any liver problems?	Yes No In the Past Current Hepatitis (A, B or C) Cirrhosis Fatty Liver Disease
Do you have any stomach problems?	Yes No In the Past Current Reflux Heart Burn Ulcer Gastritis Pain Cramping Morning Sickness Morning Vomiting

Do you have any throat problems?	Yes No In the Past Lump in the throat Painful Swallowing Hoarseness Gag Easily
Do you have any abdominal pain?	Yes No In the Past Under Right Ribs Generalized Pain Specific Pain Lower Upper Right Left Constant Intermittent Every Now & Then With Food Ileocecal History of Appenditis Appendix Removed
Antibiotics Taken Recently?	Yes No Childhood (1, 2, 3, 4, 5 ,6 more) Month ago

Tell me about your hormone function. *(Circle all that apply)*

When did you start puberty?	Not Yes 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20+
How's your sex drive?	No Problems No interest Takes a While Erectile Dysfunction Hypersexual Lack of Orgasm Increased / Decreased Sex Drive
Where do you gain weight	Hips Stomach Breasts Legs Thighs Arms Neck Face
How are your breasts?	No Problems Breast Feeding Benign Mass Lumpectomy Abnormal Thermography Abnormal Mammogram Tenderness Pain Swollen Nipple Discharge Inverted Nipples Skin Changes Changes with Period
How is your menstrual cycles	Regular PMS Cramping Irregular Cycles Short / Long Cycles Absent Periods Heavy Flow Scant Flow Painful Period
Do you have any of the following conditions?	Endometriosis PCOS Ovarian Cysts Infertility Pelvic Inflammatory Disease Peri or Post Menopause Yeast Infection Vulvitis Volvodynia
Do you have any of these symptoms?	Hot Flashes Night Sweats Vaginal Dryness Mood Swings Sudden Tearful Hair Loss Increased Hair
Do you have any of these symptoms?	Brain Fog Memory Loss Mood Change Low energy Sweat Easily Always Tired Easily Fatigued Always Cold / Hot Excessive Body Hair

Tell me about your head. *(Circle all that apply)*

How is your hair?	Normal Thinning Coarse Brittle Balding Loss of Eyebrows Loss of Hair on Lower Legs
How is your head?	No Problems Headaches Migraines Vertigo Dizziness History of Head Injury Loss of Consciousness Fainting History of Stroke
How are your eyes?	No Problems Blurred Vision Loss of Vision R / L Eye Pain Glaucoma Cataracts Near / Far Sighted Wears Glasses / Contacts Conjunctivitis Pink Eye Skin Tags Watery Eyes Dry Eyes Light Irritates Eyes Blue Tinting on White Area of Eyes Blood Vessel Engorged or Broken
How are your ears?	No Problems Ringing in Ears Loss of Hearing Ear Infections History of Ear Infections Bleeding Drainage Meniere's Fluid in Ears Swimmer's Ear Inner Ear Infection
How is your nose?	No Problems Allergies Nose bleeding Stuffy Nose Loss of Smell Sinus Trouble Chronic Sinus Infections Sneezing Post Nasal Drip

Tell me about your skin and nails. *(Circle all that apply)*

Do you have any of the following skin conditions?	Hives Eczema Psoriasis Jock Itch Candiasis Yeast Infections Athlete's Foot Ring Worm Fever Blisters Genital Herpes Peeling Skin Thin Skin
How are your finger nails?	Normal Deep Splits Ridges Deep Ridges Blue Around Base Red Around Base Yellowish Raised White Spots No Moon Hang Nails Clubbing Flat Spooning Out Curving Under at End Fungal Infection Flakey
Have you noticed strong odor problems?	Bad Breath Foul Sweat Foul Gas Foul Smelling Feet / Arm Pits
Areas that itch often?	Head Neck Face Chest Back Hands Genitals Buttocks Legs Feet
How is your skin overall?	No Problems Fragile Tears Easily Easily Irritated Warts Tiny Bumps Rashes Boils Ulcers Cysts Fungal Infections Lots of Warts Changing Moles Skin Lesions History of Skin Cancer

Tell me about your lungs. *(Circle all that apply)*

How are your lungs?	No Problems Asthma Coughing Wheezing Shortness of Breath Pneumonia Trouble Breathing Bronchitis COPD Cystic Fibrosis Lung Cancer

Tell me about your heart. *(Circle all that apply)*

How is your heart?	No Problems Chest Pain Angina (Stable or Unstable) Tight Chest Palpations High Blood Pressure Low Blood Pressure Irregular Heart Rate Murmur History of Murmur Congestive Heart Disease Bypass Surgery Open Heart Surgery Pace Maker Enlarged Heart Heart Racing
How is your pulse?	No Problems Regular Irregular Slow Fast Weak Pulse Can Hear it in Your Ears
How is your blood pressure?	No Problems High Low Flucuates Very High Very Low

Tell me about your urine. *(Circle all that apply)*

How is your urination?	No Problems Trouble Starting Trouble Stopping Incomplete Dribbling Leaking Urgency Acute UTI Chronic UTIs Burning Itching Discharge Odors Blood Wetting Bed Kidney Stones History of Kidney Stones
How does your urine appear?	Clear Lightly Yellow Dark Orange Red / Bloody Cloudy Stinks

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Do you take any medications?

Drug	Dose	Why do you take this?	Is it working or comment?

Do you have any medications allergies?

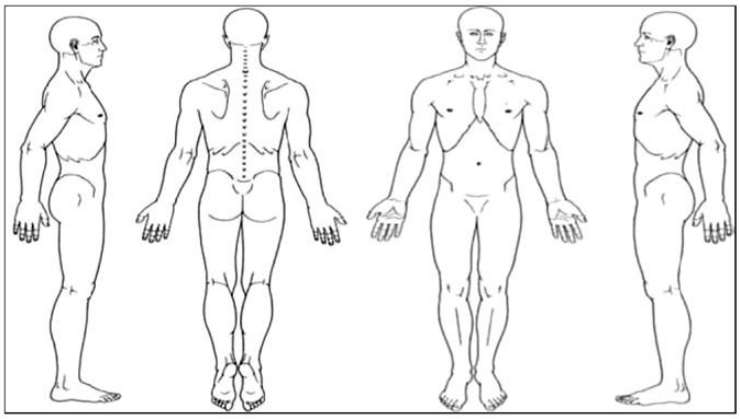
Drug	Allergic Reaction

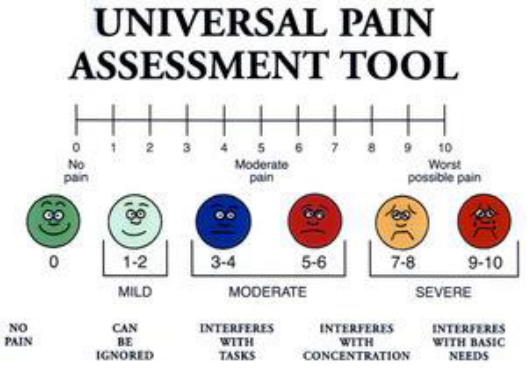
Do you take any supplements or vitamins?

Supplement name	Dose	Why do you take this?	Brand

Have you ever been hospitalized or had surgery?

Date	Reason	Outcome





Tell me about issues with how you feel overall. *(Circle all that apply)*

Emotional	Anxiety Depression Confusion Jittery Easily Startled Falling Apart Withdrawn Lonely Lost Nervous Breakdown Irritable Unusual Tension Hyperactive (ADHD) Inattentive (ADID) Hostility Anger Nightmares Numb Frustration Nervous Person Type A Personality

Tell me about the ways you deal with stress. *(Circle all that apply)*

Stress / Coping	Meditation Yoga Imagery Deep Breathing Tai Chi Prayer Hobbies
Hobbies / Leisure Activities	

Tell me about your family.

	Ages	Living	Heart Disease	Cancer	Depression	Anxiety	Arthritis	Auto-immune	Celiac	Dementia	Migraines	Hypertension	IBS	Crohn's	Obesity	Stroke
Father	/	Y / N														
Mother	/	Y / N														
Brother (s)	/ / / /	Y / N														
Sister (s)	/ / / /	Y / N														
Child (ren)	/ / / /	Y / N														
Uncles (Maternal)	/ / / /	Y / N														
Aunts (Maternal)	/ / / /	Y / N														
Grandmother (Maternal)		Y / N														
Grandfather (Maternal)		Y / N														
Uncles (Paternal)	/ / / /	Y / N														
Aunts (Paternal)	/ / / /	Y / N														
Grandfather (Paternal)		Y / N														
Grandmother (Paternal)		Y / N														

Thoughts & Considerations

Is there anything else that is important that hasn't been addressed?

_____
_____
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Health Goals

What can't you do now, that you would like to see change?

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Thank you for taking the time to fill out this comprehensive health questionnaire. I look forward to helping you achieve your health goals.

Check Each Block

What we do at the Genomic Wellness is important and it is also important that you understand what we do and what we do not do as health coaches while you are a client.

❑ I understand that my health coach may have obtained several credentials, degrees and licensure, however they are not my doctor, physician or medical provider. They are my health coach.

❑ I understand that my health coach does not prescribe medication and may educate me on the side effects, nutrient depletions, damaging effects to specific organs, etc., any changes to my medication should be **ONLY** under the supervision of my prescribing physician or mid-level practitioner.

❑ I understand that my health coach will address my underlying imbalances but does **NOT** specifically treat any "disease", especially cancer.

❑ I understand that my health coach will provide me with lifestyle changes, dietary changes, and information to help me improve my biological responses to my environment based on their expertise and knowledge.

❑ I understand that I should **ALWAYS** consult with my primary care physician and specialists to diagnose and /or treat any disease.

I have read and understand the above

_____	_____	_____
Printed Name	Signature	Date

HIPAA Compliance

The Genomic Wellness of Beverly Hills does not electronically transmit health information in connection to the Transaction Rule and thus is not a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Privacy & Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

I have read and understand the above

_____	_____	_____
_____	_____	_____
Printed Name	Signature	Date