Client Intake Form

Date:_____

First Name:_____Last Name:_____MI_____

Address: _____ City: _____ State: _____ ZIP: _____

Email Address:_____

Preferred Phone:(_____) _____-_____ Birth Date:____/____/____ Age: _____
month day year

Secondary Phone:(_____) _____-_____

Place of Birth:_____
City or town & country if not US

Occupation:_____

Height: ___' ____ " Weight: _____ Gender: ☐ Male ☐ Female

Referred by:_____

Please check appropriate boxes

☐ African American	☐ Hispanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Spouse Name _____

Health Concerns

What health and/or nutrition concerns would you like to discuss today? Rank Priorities. Any Recent diagnosis?

Medications/Supplements

Nutrition and Health Goals

Nutrition Information

How is your digestion? Any stomach or intestinal issues after you eat?

_____

When was your last bowel movement?_____How many times/day?_____

Consistency of stool: _____ Color of stool:_____Blood?_____

Are you having any food cravings? Sugar? Carbs?

Yes____ No____

If yes, what food(s)? _____

_____

Do you find yourself eating food as comfort? Yes____ No____ How often?_____

How many times a week do you cook at home? _____How many times a week do you eat out? _____

How many meals do you eat each day?_____ How many snacks do you eat each day?_____

What time do you eat dinner?_____ Do you include a lot of carbs?_____

Do you drink caffeinated beverages Yes____ No____ If yes, how many cups per day? _____

Do you drink sodas? Yes____ No____ If yes, how many per day? _____

Do you use natural or artificial sweeteners? Yes____ No____ If yes, which ones?

_____

Have you tried dieting in the past? Yes_____ No_____ How often?_____ What diet?_____

If yes, how did dieting work for you?_____

Do you have any dietary or religious restrictions in your diet? (vegan, kosher, gluten-free, etc.) Yes____ No____
If yes, please explain:

Food Diary: please record what you eat and drink in one typical 24 hour period. Include beverages, condiments, added sweeteners, and snacks.

Time	Food/Beverage	Amount (cups, oz, tsp)	Location (home/away)

Preferred Foods

_____

_____

_____

Lifestyle

How is your energy level? Rate this on a scale from 1 to 10:_____ Do you wake up rested?_____

Do you have afternoon fatigue? Yes____ No____ How often?_____
How are you doing with stress?

_____

_____

How are you doing with sleep?_____

What time do you normally fall asleep? _____ Wake up?_____

Do any of these apply to you?

☐ trouble falling asleep ☐ waking up during the night ☐ don't feel rested upon waking

Males: do you wake up in the night to pee? Yes____ No____ How often?_____

Are you exercising regularly? Yes____ No____

If yes, how many times per week and how long?

_____

_____

Do you smoke or have you ever smoked? Yes____ No____ When did you quit?_____

If yes, how much and how long?

_____

_____

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing), in order to improve your health how willing are you to:

Significantly modify your diet.....	☐5	☐4	☐3	☐2	☐1
Take several nutritional supplements each day.....	☐5	☐4	☐3	☐2	☐1
Keep a record of everything you eat each day.....	☐5	☐4	☐3	☐2	☐1
Modify your lifestyle (sleep habits, work demands).....	☐5	☐4	☐3	☐2	☐1
Practice a relaxation technique.....	☐5	☐4	☐3	☐2	☐1
Engage in regular exercise.....	☐5	☐4	☐3	☐2	☐1

Rate on a scale of 5(very confident) to 1 (not confident at all): How confident are you of your ability to organize and follow through on the above health related activities? ☐5 ☐4 ☐3 ☐2 ☐1

Rate on a scale of 5(very supportive) to 1(very unsupportive): At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

☐5 ☐4 ☐3 ☐2 ☐1

Plan of Action & Follow-up Notes:

Supplement Schedule:

Product	Morning	Lunch	Afternoon	Bedtime

Special Instructions:

HILL COUNTRY
Integrative Medicine

Dr. Christa O'Leary, D.O.

Physician Fee Schedule

New Patient Consultation (typically 60 minutes)	$350
Office visit up to 15 minutes	$75
Office visit up to 30 minutes	$150

email/phone consult per 15 minute interval	$75
Office visit up to 45 minutes	$225
Office visit up to 60 minutes	$300

Charity Lawson, M.S., CNS

Nutritionist Fee Schedule

New Client	$160
60 minute consultation	$150
45 minute consultation	$110

15 minute consultation	$35
30 minute consultation	$75
Menu planning	Varies

Fee schedule is subject to change.

HCIM accepts cash, check, credit cards and Health Savings Cards.