IIPA
INTERNATIONAL IRIDOLOGY
PRACTITIONERS ASSOCIATION

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Client Intake Form

Male: _____ Female: _____

Name:____
Address:____
City:____State:__________________ Zip_____________
Phone: Home:_____________________ Work:___________________ Cell:______________________

Are you under a Physician's care now?__________ For What?____________________________________
Primary Care Physician: ____
Current Occupation: _________________________________ Hours worked per day: ________________

Birth Date:___________________________ Age: ______ Height:______________ Weight: ___________

What is your main complaint physically? ____
____
____
____
____

Surgeries: *(List type, and approximate date and age)*
____
____
____
____
____

Any Medically Diagnosed Disease or Disorders: ____
____
____

Medications:

Name of Medication	*Dosage (strength)*	*Frequency*

Client Intake Form
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Family History of Disease or Medical Condition: ____
____
____

Genealogy Traits:
Are you more similar to your mother of your father? Explain why? ________________________________
____
____

Personal History:
Allergies:
Foods: ____
Medications: ____
Pollens, etc.: ____
Abdominal Pain: *(location)* ____
Back Problems: *(location)* ____
Joint Pain: *(location)* ____
Other Pain: *(location)* ____
Eczema/Psoriasis/other skin problems: ____
Bowel Problems: ____
Muscle Aches: *(location)* ____
Edema/Swelling: *(location)* ____
Have you ever had hepatitis? ____________________ Type: *(if known)* ____________________________
Have you ever had a blood transfusion? ____
Heart Problems: ____
Breathing Problems: ____
Do you Smoke? ___________ If yes, how many a day? __________ How long? ___________________
Have you quit smoking? __________________________ If yes, when? _____________________________
Do you use alcohol? __________________ How often? ______________________________________
Sleep: Hours per day: __________________ Exercise: _______________________________________

Females:
Menstrual cycle: _____________________________________ Menopause: _________________________
Have you ever been on the pill? ______________________________ How long? ____________________
Number of pregnancies: __________________ Number of children: ______________________________
Are you pregnant? ____
Other problems: ____

Males:
Prostate gland problems: ____
Urinary frequency: __________________________ Difficult urination: ____________________________
Other problems: ____

Complaints or Symptoms:

___ Fatigue
___ Memory Loss
___ Crave Sweets
___ Headaches
___Dizziness
___ Earaches
___ Anxiety
___ Nervousness
___ Hernias
___ Varicose Veins
___ Low Blood Sugar
___ Diabetes
___ Depression
___ Hearing Problems
___ Tire Easily
___ Constipation
___ Diarrhea
___ Hemorrhoids
___ Lack Patience
___ Shortness of Breath
___ Sinus Problems
___ Sore Throat
___ Bad Breath
___ Blood Clots
___ Poor Digestion
___ Indigestion
___ Vision Problems
___ Cold Hands/Feet
___ Burping/Belching
___ Bloating/Gas
___ Nagging Cough
___ Temper Problems
___ Difficulty Sleeping
___ Dental Problems
___ Low Blood Pressure
___ High Blood Pressure

Habits: **(***How much each day?)*

Bread:____
Coffee: _______________________________________
Fried Foods: __________________________________
Water: ____
Sugar: ____
Junk Foods: ___________________________________
Green Leafy Vegetables: ________________________
Fresh Fruit: ___________________________________

Childhood History:

___ Asthma
___ Chicken Pox
___ Colds
___ Earaches/tubes
___ Tonsillitis
___ Measles
___ Pneumonia
___ Scarlet Fever
___ Tuberculosis
___ Mumps
___ Scoliosis
___ Hay Fever/Allergies

Other:____
Childhood Immunizations: ____
Other Immunizations: ____

Is there any other medical information you feel I should know about? ___________________________
____
____

What are you goals or expectations? ____
____
____
____