# ORCHARD HOLISTIC MEDICINE
# SUPPLEMENTAL INTAKE FORM

Name:_____Date of Birth:_____Date:_____

**Digestion**

| | | | | |
|---|---|---|---|---|
| Are you bloated or burping after meals? | Never | Sometimes | Often | Always |
| Does food seem to sit in your stomach? | Never | Sometimes | Often | Always |
| Are you hungry less than 2 hours after meals? | Never | Sometimes | Often | Always |
| Do you have food allergies/reactions | Never | Sometimes | Often | Always |
| Describe: | | | | |
| | | | | |

**Elimination**

| | | | | |
|---|---|---|---|---|
| How frequent are your bowel movements? | _____ times per (day/week) | | | |
| Color of stool? (Check all that apply) | ○Dark brown ○Light Brown ○Tan ○Gray ○Green ○Black ○Other:_____ | | | |
| Do you have mucus in your stool? | Never/unsure | Sometimes | Often | Always |
| Do you have undigested food in your stool? | Never/unsure | Sometimes | Often | Always |
| Stool consistency | Soft Formed Hard Diarrhea Constipation Other: | | | |

**Physical Activity**

| Exercise | Type | Frequency | Duration | Sore Easily? | Recovery time? | Enjoy? |
|---|---|---|---|---|---|---|
| Aerobic | | | | | | |
| Strength | | | | | | |
| Stretch | | | | | | |
| Sports | | | | | | |
| Walks | | | | | | |
| Other | | | | | | |
| Limitations to Exercise: | | | | | | |
| Comments: | | | | | | |

**Environmental Exposures**

○Furry or feather animals? ○Smoking history? ○Second hand smoke?
○Forced Air Heat? ○Wood Heat? ○Eat from garden? ○Basement?
○Crawlspace?
○Sleep near cell phone? ○Sleep near outlets? ○My bedroom is above the garage.
Type of water filtration?
Type of air filter?
How often do you replace or wash your pillow?
What is the (approximate) year of your home?
What type of flooring is in your bedroom?
What type of flooring is in the rest of your home?

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**Food and Nutrition History**

| | | |
|---|---|---|
| Favorite Foods: | | |
| Foods that make you feel good: | | |
| Foods that make you feel bad: | | |
| Foods you avoid as a matter of principle: | | |
| Foods you crave: | | |
| Check all the factors that apply to your current lifestyle and eating habits: | | |
| O Love to eat | O Eat because I have to | O Fast eater |
| O Eat too much | O Emotional eater | O Late night eating |
| O Erratic eating patterns | O Negative relationship with food | O Eating in the middle of the night |
| O Time constraints | O Don't care to cook | O Travel frequently |
| O Challenges obtaining healthy foods | O Do not plan meals or menus | O Reliance on convenience items |
| O Poor snack choices | O Food associated with pain | O Eat alone |
| O Confused about nutrition advice | O Wake hungry at night | O Others I eat with don't eat healthy |

**Lifestyle**

| |
|---|
| Daily Stressors (rate on a scale of 1-10 with 10 being most distressing)<br>Health:_____Work:_____Family:_____Social:_____Finances:_____<br>Other: |
| Hobbies or activities that "recharge" you:<br>Stress/coping techniques: |
| Sleep habits:<br>Average hours per night: O>10 O8-9 O6-8 O<6 Bedtime:_____Wakeup:_____ |
| Sleep concerns: OInsomnia OAwakening OSnoring OAwake un-refreshed<br>OTrouble falling asleep |
| On a scale of 1-10, please rate your average energy level (1=low, 10=high): |
| Ofatigue during the day. What time? |

**Diet Recall (last 24 hours or a typical meal)**

| Meal | Describe | Time: |
|---|---|---|
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks | | |
| Water | How many 8oz cups of water per day? | |

**Mood (select all that apply)**

| |
|---|
| O Negative mood O Irritable O Sad/weepy O fluctuating through day/week |