Nutrify Wellness Intake Form

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Please take your time filling out this intake form, being as thorough as possible. The more information that is gathered before the initial consultation, the more productive and customized your appointment can be, allowing you to get the most out of your time and money. If you wish to have any additional information evaluated, such as lab tests, food diaries, etc., please include them when returning this form. ***Attaching iris photos is also very helpful.***

Personal Information		
Name:	Gender:	Date:
Address:		
City:	State:	Zip:
Cell #:	Home #:	Do you text? ☐ Yes ☐ No
Email:	DOB:	
Occupation:	Age:	
Referred by:		

Vitals Information *(Leave blank if unknown)*		
Eye Color:	Blood Type:	Basal Temp: °
Blood Pressure (Left):	Blood Pressure (Right):	If you only know one reading, enter in left.
Saliva pH:	Urine pH:	
Height: _____' _____"	Weight: _____ lbs	
How many bowel movements do you have per day?		
How many ounces of water do you drink on avg daily? _____oz.	What kind?:	
How often do you move your bowels per week? ☐Daily ☐Every other day ☐Twice weekly ☐Once weekly		
How would you describe your average energy level? (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10		

Nutrition Information

What other liquids do you drink? Select and input frequency:		1D = once daily, 2W=twice weekly, 3M = 3 times monthly Example: ☒ Coffee -3D (3 times daily)
☐ Coffee – _____	☐ Tea – _____	☐ Soda Pop – _____
☐ Alcohol – _____	☐ Milk – _____	☐ Energy Drink – _____
☐ Other (_____) – _____		☐ Other (_____) – _____

What type of foods do you crave?	☐ Salty	☐ Sweets	☐ Breads/Pastas	☐ Chocolate
☐ Cheese	☐ Red Meat	☐ Other (_____)	☐ Other (_____)	

Which of the following do you consume? Select and input frequency.		1D = once daily, 2W=twice weekly, 3M = 3 times monthly Example: ☒ Coffee -3D (3 times daily)
☐ Fast Food – _____	☐ Raw Veggies – _____	☐ Processed Sugar – _____
☐ Meat – _____	☐ Raw Fruit – _____	☐ White Flour – _____
Are you currently on an eating program? ☐ Yes ☐ No		If yes, what?:

Describe the foods you eat in an average 48 hour time period. Be honest! :)

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

How often do you eat out? (circle one) Every Meal Once Daily Once Weekly Once Monthly Rarely Ever

Feel free to share any other information about your eating habits here:

_____

_____

_____

Lifestyle Information

How much exercise do you get per week? (circle one) Never 1-2 Times 3-4 Times 4-5 Times Daily

What type of exercise?

How many hours of sleep do you get on a typical night?

Check any that apply: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Night Terrors

☐ I work nights ☐ I must use sleep aids ☐ I awake feeling unrefreshed in the morning

Do you currently smoke? ☐ Yes ☐ No If so, how many cigarettes per day?

How many hours of TV do you watch/week? How many hours spent with loved ones/week?

Do you feel fulfilled & happy in your life? ☐Yes ☐No ☐Only Sometimes

Do you enjoy your job? ☐ Yes ☐ No Is your job a major source of stress? ☐ Yes ☐ No

Do you regularly take time for spiritual nourishment (prayer, meditation, yoga, etc.)? ☐ Yes ☐ No

Do you regularly take time to care for yourself (self-love, affirmations, deep breathing)? ☐ Yes ☐ No

What are the major stressors in your life (positive or negative) and how do you deal with them?

_____

_____

Are you having a hard time coping with the stress in your life? ☐Yes ☐No ☐Sometimes

Is your relationship with your significant other fulfilling? ☐Yes ☐No ☐Only Sometimes ☐N/A

Do you feel fulfilled in your social life? ☐Yes ☐No ☐Only Sometimes ☐N/A

Do you have the emotional support system you need? ☐Yes ☐No ☐Only Sometimes

Have you experienced any trauma(s) in your life (of any nature)? ☐Yes ☐No ☐Not Sure ☐N/A

IF you feel comfortable, please explain: (divorce, death of loved one, ANY type of abuse {physical, emotional, spiritual, sexual}, accidents, or ANY other experience that you feel was traumatizing to you).

_____

_____

Wellness Assessment Questionnaire

THYROID/PARATHYROID	
☐ YES ☐NO	Do you get hold hands and feet?
☐ YES ☐NO	Do you have increased sensitivity or intolerance to cold?
☐ YES ☐NO	Do you find it easy to put weight on and hard to lose it?
☐ YES ☐NO	Fingernails: ridged ☐ brittle ☐ or weak ☐
☐ YES ☐NO	Do you have varicose or spider veins?
☐ YES ☐NO	Do you, or have you had, hemorrhoids?
☐ YES ☐NO	Do you, or have you had, prolapsed organs?
☐ YES ☐NO	Do you get cramping in your muscles?
☐ YES ☐NO	Do you have an irregular heartbeat?
☐ YES ☐NO	Do you get headaches or migraines?
☐ YES ☐NO	Have you ever had a hernia?
☐ YES ☐NO	Do you have osteoporosis?
☐ YES ☐NO	Do you have scoliosis?
☐ YES ☐NO	Have you experienced excessive hair loss?
☐ YES ☐NO	Do you ever suffer from symptoms of depression?
☐ YES ☐NO	Did you score low on your bone density tests?
☐ YES ☐NO	Do your tests come back showing low calcium levels?
☐ YES ☐NO	Do you have, or have you ever had, a goiter?
☐ YES ☐NO	Do you have spine deterioration, herniated discs, or bone spurs?
☐ YES ☐NO	Have you ever been diagnosed with Hashimoto's ☐ or Graves ☐?
☐ YES ☐NO	Has a family member? If so, who?
☐ YES ☐NO	Do you bruise easily? (parathyroid)

PANCREAS	
☐ YES ☐NO	Do you get gas/bloating during or after you eat?
☐ YES ☐NO	Do you feel your foods just sitting in your stomach?
☐ YES ☐NO	Do you notice warts and/or skin tags on your skin?
☐ YES ☐NO	Do you often see undigested food in your stool?
☐ YES ☐NO	Do your foods often pass right through you (diarrhea)?
☐ YES ☐NO	Are you thin and have a hard time putting on weight?

ADRENAL/GLANDULAR SYSTEM
☐ YES ☐NO Do you have a hard time waking up in the morning?
☐ YES ☐NO Do you ever have anxiety attacks or feel overly anxious?
☐ YES ☐NO Do you have tremors, jerks, nervous legs, etc?
☐ YES ☐NO Do you have hypoglycemia (low blood sugar)?
☐ YES ☐NO Do you have diabetes? Type 1 ☐ Type 2 ☐
☐ YES ☐NO Do you have tinnitus (ringing in the ears)?
☐ YES ☐NO Do you have shortness of breath or a hard time taking a deep breath?
☐ YES ☐NO Do you have heart arrhythmias?
☐ YES ☐NO Do you experience chronic low back pain?
☐ YES ☐NO Do you crave salty foods?
☐ YES ☐NO Do you have a hard time sleeping or insomnia?
☐ YES ☐NO Do you have continued fatigue not relieved by sleep?
☐ YES ☐NO Have you ever been diagnosed with Addison's ☐ or Cushing's ☐?
☐ YES ☐NO Do you feel you have a decreased ability to deal with stress?
☐ YES ☐NO Does it take you longer than usual to recover from illness, injury, trauma, etc?
☐ YES ☐NO Do you often get light headed or dizzy if you stand up too quickly?
☐ YES ☐NO Do you often get light headed or dizzy in a warm shower?
☐ YES ☐NO Do you startle easily? ☐ YES ☐NO Are you easily irritated?
☐ YES ☐NO Have you taken long term or intense steroid therapy (corticosteroids)?
☐ YES ☐NO Do you suffer from PTSD (post-traumatic stress disorder)?
☐ YES ☐NO Are you easily fatigued and everything feels like a chore?
☐ YES ☐NO Do you experience "brain fog" (decreased thought clarity) or poor memory?
☐ YES ☐NO Do you have elevated blood cholesterol levels?
☐ YES ☐NO Do you have high (☐)or low (☐) blood pressure?
☐ YES ☐NO Do you been diagnosed with M.S. (☐), Parkinson's (☐) , or Palsy (☐)?
☐ YES ☐NO Have you had recurring bouts of bronchitis, pneumonia, asthma, sinusitis or other respiratory infections? Please indicate: _____
☐ YES ☐NO Do you have arthritis, bursitis, or any other "itis's" (inflammatory conditions)? If yes, list conditions here: _____

LYMPHATIC SYSTEM

☐ YES ☐NO Have you ever had lymph nodes removed?

☐ YES ☐NO Do you often get a sore throat?

☐ YES ☐NO Do you have, or have you had, swollen lymph nodes?

☐ YES ☐NO Do you have a hard time remembering things?

☐ YES ☐NO Do you experience allergies?

☐ YES ☐NO Do you get boils, pimples, cysts, acne, etc.?

☐ YES ☐NO Do you feel that your immune system is weak or sluggish?

☐ YES ☐NO Have you had your tonsils out? If so, at what age:

☐ YES ☐NO Do you have, or have you had, cellulitis?

☐ YES ☐NO Do you get colds and flu-like symptoms?

☐ YES ☐NO Do you experience pressure, stiffness or pain in your shoulders and neck area?

☐ YES ☐NO Do you have excess mucous drainage, especially in the morning or after meals?

☐ YES ☐NO Do you wake up with joint pain/stiffness that is alleviated as you get moving?

☐ YES ☐NO Do you experience pressure headaches, including sinus pressure?

☐ YES ☐NO Do you snore? ☐ YES ☐NO Do you have sleep apnea?

☐ YES ☐NO Do you regularly experience sinus congestion?

☐ YES ☐NO Do you often experience an overall "yucky" feeling?

☐ YES ☐NO Do you have, or have you had, tumors? If so, where:

How much do you sweat? ☐None ☐Low ☐Medium ☐ Excessive

What brand of deodorant do you use?

KIDNEYS/BLADDER

☐ YES ☐NO Have you ever had a urinary tract infection (UTI)?

☐ YES ☐NO Have you ever had "burning" upon urination?

☐ YES ☐NO Do you have problems holding your bladder? (parathyroid)

☐ YES ☐NO Have you ever had kidney stones?

☐ YES ☐NO Do you have bags under your eyes (especially in the morning)?

☐ YES ☐NO Do you get cramping or pain on either side of your mid-lower back?

☐ YES ☐NO Do you, or have you ever had, nephritis?

☐ YES ☐NO Do you have frequent urination?

GASTRO-INTESTINAL TRACT

☐ YES ☐NO Have you been diagnosed with any GI issues?(chrohn's, UC, celiac, diverticulitis, IBS, IBD, SIBO, FODMAPS, etc) If yes, please indicate:

☐ YES ☐NO Have you been diagnosed with any autoimmune disorders?
If yes, please indicate:

☐ YES ☐NO ☐ UNKNOWN Were you breastfed as a baby?

☐ YES ☐NO Do you experience acid reflux (GERD)?

☐ YES ☐NO Does your digestive system rule your life?

☐ YES ☐NO Do you regularly experience abdominal pain?

☐ YES ☐NO Do you get diarrhea? How often:

☐ YES ☐NO Do you experience constipation? How often:

☐ YES ☐NO Have you ever had stomach or intestinal ulcers?

☐ YES ☐NO Do you struggle with an eating disorder? Please indicate:

☐ YES ☐NO Is your tongue coated (white, yellow, green, brown), especially in the morning?

☐ YES ☐NO Do you experience gas, bloating and/or stomach pain after meals?

☐ YES ☐NO Do you have, or have you had, any type of gastro-intestinal cancers?
If yes, explain:

Please elaborate on any of the above issues and/or discuss any other GI problems:

_____

_____

_____

LIVER/GALLBLADDER

☐ YES ☐NO Do you have trouble digesting fats?

☐ YES ☐NO Are your stools white or very light brown in color?

☐ YES ☐NO Do you get pain in the middle of your back, especially after eating?

☐ YES ☐NO Do you have "liver" or brown spots on your skin? (Not freckles)

☐ YES ☐NO Are you jaundiced (yellowing of the skin)?

☐ YES ☐NO Are you, or have you ever been, anemic?

☐ YES ☐NO Do you experience, or expect you are experiencing, estrogen dominance?

☐ YES ☐NO Do you experience pain/tenderness behind the right, lower rib area?

☐ YES ☐NO Do you have any skin pigmentation changes?

☐ YES ☐NO Do you frequently experience nausea or vomiting, especially after meals?

HEART/CIRCULATION	
☐ YES ☐NO	Do you experience chest pains?
☐ YES ☐NO	Have you ever had a heart attack?
☐ YES ☐NO	Have you ever had open heart surgery?
☐ YES ☐NO	Do you have a heart murmur or Mitral Valve Prolapse?
☐ YES ☐NO	Do you ever feel pressure on your chest?
☐ YES ☐NO	Do you get "prickly" pains anywhere, especially in the heart area?
☐ YES ☐NO	Do you have, or have you ever had, high blood pressure?
☐ YES ☐NO	Do you have a pacemaker ☐ or stents ☐?

LUNGS	
☐ YES ☐NO	Do you get, have, or have had bronchitis?
☐ YES ☐NO	Do you get, have, or have had emphysema?
☐ YES ☐NO	Do you get, have, or have had asthma?
☐ YES ☐NO	Do you get, have, or have had C.O.P.D.?
☐ YES ☐NO	Do you have pain when you breathe?
☐ YES ☐NO	Do you have pain when you take a deep breath?
☐ YES ☐NO	Is it difficult to take a deep breath?
☐ YES ☐NO	Do you have, or have you ever had, lung cancer?
☐ YES ☐NO	Do you have a collapsed lung?
☐ YES ☐NO	Have you ever had pneumonia?
☐ YES ☐NO	Have you ever worked around toxic chemicals, in coal mines, or with asbestos?
☐ YES ☐NO	Do you cough a lot?
☐ YES ☐NO	Have you gone through (or going through) deep grief in your life?
☐ YES ☐NO	Do you get any mucous when you cough? If so, what color?
☐ YES ☐NO	Are you on any inhalers or nebulizers? How often?: What type?:

FEMALES ONLY

☐ Not yet menstruating ☐ Menstruating ☐ Pre-menopausal ☐ Menopausal ☐ Post-menopausal

☐ YES ☐NO ☐ N/A Is your cycle regular? (pituitary)

☐ YES ☐NO ☐ N/A Do you get excessive bleeding during menstruation?

☐ YES ☐NO ☐ N/A Do you have painful cramping during menstruation?

☐ YES ☐NO Do you have, or have you had, ovarian cysts ☐, uterine fibroids ☐ or endometriosis ☐?

☐ YES ☐NO Do you experience abnormal body hair growth (especially on face, breasts, arms, etc)?

☐ YES ☐NO Do you have, or have you had, A-typical cells (abnormal PAP)?

☐ YES ☐NO Do you have, or have you had, fibrocystic breasts?

☐ YES ☐NO Do you get sore breasts, especially right before and during menstruation?

☐ YES ☐NO Have you had difficulty conceiving children? ☐ YES ☐NO Have you had a miscarriage?

☐ YES ☐NO Have you been on birth control pills? How long:

☐ YES ☐NO Are you currently pregnant?

☐ YES ☐NO Do you experience mood swings?

☐ YES ☐NO Have you given birth? How many children?:
Vaginal or Cesarean?

☐ YES ☐NO Have you had a hysterectomy? Date: ☐ Partial ☐ Complete

Check all that apply: ☐hot flashes ☐vaginal dryness ☐weight gain ☐fatigue ☐PMS ☐anxiety

How would you describe your libido (sex drive)? ☐ Non-existent ☐ Low ☐ Normal ☐ Excessive

Describe any other female related issues/symptoms you wish to share or elaborate upon:

_____

_____

MALES ONLY

☐ YES ☐NO Do you have prostatitis (inflammation of the prostate)?

☐ YES ☐NO Do you have frequent urination, especially at night?

☐ YES ☐NO Do you have prostate cancer? PSA count: Date:

Describe any other male related issues you wish to share:

_____

_____

SKIN

☐ YES ☐NO Do you get or have skin rashes?

☐ YES ☐NO Do you get skin blemishes?

☐ YES ☐NO Do you experience eczema or dermatitis?

☐ YES ☐NO Do you have psoriasis?

☐ YES ☐NO Do you itch anywhere? Where?

☐ YES ☐NO Is your skin dry?

☐ YES ☐NO Is your skin excessively oily?

☐ YES ☐NO Do you get or have dandruff? (lymphatics)

☐ YES ☐NO Do you have any other skin issues? Is so, explain:

Please describe any products that are applied to your skin (lotions, soaps, perfumes, makeup, etc.):

_____

_____

ENVIRONMENTAL

☐ YES ☐NO Have you ever been vaccinated?

☐ YES ☐NO Have you had flu shots?

☐ YES ☐NO Have you had mercury dental fillings?

☐ YES ☐NO Have you ever used paints, stains, lacquer, etc. without a proper respirator?

☐ YES ☐NO Have you (or expect that you have) been exposed to mold?

☐ YES ☐NO Have you ever spent considerable time in freshly painted or newly carpeted rooms?

☐ YES ☐NO Do you experience chemical sensitivity?

☐ YES ☐NO Do you bathe in water that contains chlorine?

☐ YES ☐NO Do you frequently visit the nail salon?

☐ YES ☐NO Do you use candles, air fresheners, car fresheners, etc.?

☐ YES ☐NO Have you ever had radiation ☐ or chemotherapy ☐
If so, how many treatments?:

What kind of laundry detergent/fabric softener do you use? (Tide, Downy, homemade, etc)

_____

What kinds of cleaning chemicals do you use? (Bleach, Windex, 409, vinegar, baking soda, etc)

_____

CHEMICAL MEDICATIONS	
Medication Name	Reason for taking/frequency
•	•
•	•
•	•
•	•
•	•
•	•

SUPPLEMENTS/HERBS/ETC. (List any natural supplements, including brands, you are currently taking)	
•	•
•	•
•	•
•	•
•	•
•	•

ALLERGIES (List anything that you are allergic to; food, environmental, etc.)	
•	•
•	•
•	•
•	•
•	•

PAST SURGERIES (List any past surgeries, minor and major, and the year.)	
Surgery	Date (MM/YYYY)
•	•
•	•
•	•
•	•
•	•

GENETIC/FAMILY MEDICAL HISTORY

(List the health issues each family member has/had.)

Mother:
Father:
Grandfather (Maternal):
Grandmother (Maternal):
Grandfather (Paternal):
Grandfather (Paternal):
Sister:
Sister:
Brother:
Brother:

TOP 3 HEALTH CONCERNS

(Discuss your top 3 health concerns. EXAMPLE: fatigue, bladder infections, digestive issues)

_____

_____

_____

ADDITIONAL HEALTH CONCERNS

(Freely discuss additional concerns and elaborate on anything you indicated on this form.)

_____

_____

_____

_____

_____

_____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so. Your medical history, ***without*** *your name or personal information, might be used in teachings by RuthAnna Autry and Nutrify Wellness.*

Nutrify Wellness Disclaimer

I _____, hereby attest and agree to the following:

I fully understand that RuthAnna Autry is a Board Certified Naturopath who deals strictly in helping people to improve their general health and fitness through better nutrition, improved lifestyle, health habits, and positive mental attitudes.

I fully understand that RuthAnna Autry is NOT a licensed medical doctor; nor should any of her actions or comments be construed as such. RuthAnna cannot and does not diagnose diseases, prescribe drugs, recommend treatments for specific disease conditions, cure, prevent, or heal disease or make any claims thereof. I fully understand that I am not here for medical diagnostic purposes or treatment procedures.

I understand that all evaluations performed by RuthAnna Autry or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits, and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have, and do not replace the diagnostic services offered by licensed physicians.

I understand that RuthAnna Autry neither claims, nor implies, that any instruction, advice, counsel, suggestions, recommendations, services, or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent, or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems, and otherwise improving general health and fitness.

I understand that RuthAnna Autry or her representatives will not suggest that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold RuthAnna Autry, Nutrify Wellness LLC, or her representatives responsible for the consequences of my decisions. I release RuthAnna Autry and and Nutrify Wellness LLC from any past, present or future health related liability issues. My own personal body may have the ability to heal itself, and I am choosing my own actions to facilitate a healing of my OWN body. I consent to participate in this education demonstration about MY body.

I understand that RuthAnna Autry believes that genuine healing comes only from God, and that God has provided simple and natural methods such as rest, nutrition, herbs, exercise, attitude changes, and touch to help people recover and maintain their health. I further understand that RuthAnna Autry shares these methods with others as part of her God-given and constitutional rights of freedom of speech and freedom of religion.

Name of Client: _____

Signature: _____ Date: _____
(Signature of parent/guardian if for a child)

Printed Name: _____