POLO
HEALTH + LONGEVITY CENTRE

Client Intake Form		
Personal Information		
Name:		Date:
Birthday:	Age:	Gender:
Address:		
Email:		
Home Phone:		Cell Number:
Occupation:		
Relationship Status:		
Emergency Contact Name and Phone Number:		
Health and Wellness Goals		
What brings you to this nutritional consultation today?		
What are your primary health and wellness goals/ concerns?		
What would you like to accomplish regarding your health & wellness?		
Have you previously utilized nutritional or lifestyle protocols for the betterment of your health and wellness, and if so what were they and what were your results?		
Are there any obstacles or challenges that you believe may make it difficult to achieve your health and wellness goals?		
Family History (indicate current or past family conditions and illnesses)		
Mother:		
Father:		
Maternal Grandparents:		

Paternal Grandparents:
Siblings:
Women's Health
Do you have regular periods? ☐Yes ☐No
List any PMS symptoms:
Are you taking birth control? ☐Yes ☐No For how long?
Have you had menopause? ☐Yes ☐No When?
Men's Health
Do you have erectile concerns?
Do you have prostate concerns?
Medications and Supplements
Are you currently being treated for a medical condition? List medications you are taking for this condition:
List any other medications you are taking:
List any supplements you are currently talking (including vitamins, minerals, probiotics, etc.)
Allergies or Sensitivities (food, drug, seasonal, chemical, other)
When did you last take oral antibiotics?
Dental History
Food Habits
Are you currently following a specific diet? ☐Vegan ☐Vegetarian ☐Gluten-free ☐Dairy-free ☐Paleo ☐Other Explain:

Do you typically eat breakfast?
How many meals do you eat per day?
How often do you eat out at restaurants?
How often do you eat packaged or frozen food?
Do you drink alcohol? How often? Do you smoke cigarettes? How often?
What foods do you typically crave? ☐Sweet ☐Salty ☐Bread/Pasta ☐Caffeine ☐Other
How much water do you consume in a day?
What other beverages do you typically consume?
Do you often feel hungry? ☐Yes ☐No
What 5 foods do you eat most frequently? 1) 2) 3) 4) 5)
Indicate all that apply to your current state of being, lifestyle and eating habits ☐Eat too much ☐Erratic eating patterns ☐Late night eating ☐Fast eater ☐Often skip meals ☐Afternoon fatigue ☐Frequent colds/illness ☐Do not plan meals/eat on the run
Digestion
How often do you have a bowel movement?
Describe your bowel movements: ☐Hard and small ☐Loose and watery ☐Soft and well formed
Do you suffer from any of the following: ☐Gas ☐Bloating ☐Cramping ☐Constipation ☐Diarrhea
Lifestyle
Describe your typical energy levels:
How often do you exercise? Type of exercise:
Describe your sleeping patterns (sleep soundly, wake-up often, difficulty falling asleep, etc).
Do you feel rested upon waking?

What is your current stress level? ☐Low ☐Mid ☐High
What do you think is the leading cause of stress for you?
Additional Comments/ Concerns:
Informed Consent
· Nutrition and exercise are intended to promote general health and wellness and are not intended to replace medical care. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input, and are not intended to diagnose, treat or cure any disease or ailment. · Any activity or program may have inherent risks which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself. You agree to inquire about any activities with which you are not familiar, and provide any information which may limit your participation in suggested activities. · Results and changes in your general health and wellness may vary depending on medical conditions, medications, and accuracy in following suggested guidelines. · Never reduce or eliminate physician prescribed medications without the direction of a medical care provider.
Name:
Signature: Date: