Name: _____ **Date:** _____

Name: _____ **Age:** _____

Birthdate: _____ **Gender:** _____

Phone Number: _____

Email: _____

Address: _____

_____

Height: _____ **Weight:** _____ **Ideal Weight:** _____

Occupation: _____

(Circle one) **Married / Single / Divorced / Widowed**

Military? Y / N

Family members or pets in the household?

_____

_____

Referral: _____

Practitioner: _____

We now save credit cards on file

to take pre-payment for your initial consultation. You will also be charged for missed appointments and recurring cancellations less than 24 hours. See our missed appointment policy for details.

CC Number: _____

Security Code: _____

Expiration Date: ____/_____

Zipcode: _____

---

4 Main Goals (Prioritized)

1._____ 3._____

2._____ 4._____

What are you most looking to get out of these services with us?

_____

What do you see being your biggest challenge for you to accomplish your goals?

_____

How willing are you to make adjustments with your time, social life, finances, and even sleep to achieve these goals?

_____

What will you absolutely not give up or change?

_____

What is one area you know you can change now to improve how you feel?

_____

Is there anything that scares or intimidates you about following a nutrition plan?

_____

Share any previous experience with alternative practitioners or what you have tried:

_____

_____

_____

_____

Medical History

If you are currently under the care of a medical professional, please list name, clinic, and date of last visit: _____

Blood Type: _____

Do you regularly get vaccinated for flu, covid, or other? _____

Have you ever taken any of the following? (circle all that apply)

Iron Vitamin D3 Calcium Zinc Molybdenum "Drugstore" Once-aDay Prenatals Synthetic Vitamin C (Ascorbic Acid) High Fructose Corn Syrup Fluoride

Have you had Iron infusions? Y / N

Have you had any surgeries/when?

_____

_____

Do you have any medical diagnoses?

_____

Any Mercury/Metal Fillings? Y / N

Have You Had Metal Fillings Removed? Y / N

Any root canals? Y / N

List any special diet or dietary restrictions/why (ex. Gluten Free, LowFodmap, LowOxilate)**:**

_____

Any allergies?

_____

Females

(circle one) **Menstrual Cycling** **Perimenopause** **Menopause** **Postmenopause**

If under the age of menopause, do you currently get a cycle/period? Y / N

Are you pregnant or breastfeeding or having difficulties getting pregnant?

_____

What have been the characteristics of your menstrual cycle, or post-menopause?

_____

Do you use birth control or hormone replacement therapy?

_____

If you have been on birth control, how long? _____

If you have stopped birth control, when? _____

Intake

How much water do you drink in a day? _____

Do you use a filter for drinking or shower water? Y / N **If so, what kind?** _____

What other beverages do you drink and how much?

_____

What do you use for sweetener? (Suclarose found in most energy drinks count)

_____

Are you usually hungry for breakfast? Y / N

Describe what you typically eat for Breakfast Lunch, and Dinner:

B_____

L_____

D_____

Do you follow a fasting schedule? Y / N

Would you say you have a negative relationship with food? Y / N

Do you get cravings? If so, for what, and generally when do you get them?

_____

Mostly eat from: (Circle one) **Usually Homecooked** **Eat Out Alot** **About Half and Half**

Where and how do you typically eat? (Ex. standing, while working, at the table with family, on the go)

_____

Movement

Do you exercise? Y/ N **If so, how?** _____

Do you enjoy it? Y/N **What time of the day do you typically work out?** _____

How do you feel when you are finished? _____

Digestion

How often do you have a bowel movement? _____

Is it difficult, easy, or do you get the runs? _____

Do you have any digestive issues like pain, bloating, acid reflux, or flatulence?

_____

Stress Assess

What do you do to relax?

_____

Rate your stress level: Low 1 Medium 2 High 3

What time do you go to bed? _____ **Wake?** _____

How many hours do you get restful sleep? _____

Do you wake with pain? Y / N **Does it go away upon moving?** Y / N

Do you feel rested when you wake? Y / N

What is your current living situation?(circle one) Stable About To Move Recently Moved It's Complicated

Do you have anyone you are supporting in an ongoing way? Grown kid or family member, etc?

_____

Are there any environmental exposure concerns you are facing? (circle one)

1. Mold In The House Or At Work 2. High Chem Exposure At Work 3. Known Issues With Your Water

Other: _____

How would you describe your childhood? (circle one)

Stable Moving Constantly Traumatic Safe & Enjoyable Sick a Lot Hard

Have you smoked cigarettes/cigars? _____

Recreational use of drugs? (confidential) _____

Do you drink alcohol? If so, how much/often? _____

Extra Relevant Info (Client Fills In**):**

_____

_____

_____

_____

_____

_____

Missed Appointment Policy

At Langlois' Vital Nutrition Center, we ask our clients for a minimum of 24-hours notice for all appointment cancellations or reschedules. This provides respect to our practitioners, their time, and affords them the option to help as many clients as possible within the time they have made available.

We understand that life is unpredictable and occasions may arise that require you to change appointments, so we have implemented a "3-Strike" Policy for appointments canceled less than 24-hours in advance of the scheduled appointment time:

- ✘ **Strike 1:** No charge.
- ✘ **Strike 2:** Client will be charged 50% of the appointment fee
- ✘ **Strike 3:** Client will be charged a fee equivalent to consultation price.

Initial Here That You Understand: _____

List all current **MEDICATIONS** and/or **SUPPLEMENTS**

YOUR NAME: _____ DATE: _____

NAME/BRAND DOSE

1. _____ _____

2. _____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

7._____ _____

8._____ _____

9._____ _____

10._____ _____

11._____ _____

12._____ _____

13._____ _____

14._____ _____

15._____ _____

16. _____ _____

17. _____ _____

18. _____ _____

19. _____ _____

20. _____ _____