Name:

Date of Birth:

Address:

NES HEALTH INTAKE FORM

Practitioner: Meena Sethi

Basic Information

1. Height
2. Weight
3. Occupation
4. Movement/exercise from occupation
   - ☐ lots of movement/exercise
   - ☐ some movement / exercise
   - ☐ very little movement / exercise
5. Stress levels from occupation
   - ☐ High levels of stress
   - ☐ Moderate levels of stress
   - ☐ Low levels of stress

Lifestyle

6. Indicate which of the following apply to you
   - ☐ I live alone
   - ☐ I am recently bereaved
   - ☐ I a recently divorced or separated
   - ☐ I have recently become a parent
   - ☐ I am the main care provider in my family
   - ☐ I work long or irregular work hours.
   - ☐ I find it difficult to cope with my workload
   - ☐ I feel supported by the people around me
   - ☐ I feel guilty when I am relaxing
   - ☐ I spend a lot of time in front of a TV or computer
   - ☐ I am often using a mobile phone or tablet
   - ☐ I am a frequent flyer
   - ☐ I use aluminum cookware/foil
   - ☐ I drink from plastic bottles or wrap food in plastic
   - ☐ I try to use natural/organic home cleaning products
   - ☐ I use aluminum-free deodorant
   - ☐ I use fluoride-free toothpaste
   - ☐ I choose products free of toxins like BPA, Parabens, phthalates lead & more.
   - ☐ I get regular vaccinations

Continued on following page

☐ I'm highly sensitive to perfumes & other chemical products / smells
☐ I feel ready to make a change

7. How many times per week do you exercise for at least 30 mins?
   - ☐ 0 times / week
   - ☐ 1-2 times / week
   - ☐ 3-4 times / week
   - ☐ 5+ times / week

8. Which of these exercises do you do in a typical week? (Choose all that apply).
   - ☐ Aerobics
   - ☐ Basketball
   - ☐ Biking / Cycling
   - ☐ Body Building / Weight Lifting
   - ☐ Cardio Workouts (non-american)
   - ☐ Fitness Classes
   - ☐ Gymnastics
   - ☐ High Intensity Interval Training
   - ☐ Other
   - ☐ Hiking
   - ☐ Jogging/ Running
   - ☐ Martial arts
   - ☐ Rowing/ kayaking/ paddle board
   - ☐ Soccer/ Football
   - ☐ Tennis
   - ☐ Walking
   - ☐ Yoga

9. What do you do to relax?

10. How many hours of sleep do you get on a typical night?
    - ☐ 0-3 hours
    - ☐ 6-8 hours
    - ☐ 4-6 hours
    - ☐ 8+ hours

11. How would you rate the quality of your sleep?
    - ☐ Very good
    - ☐ Ok, some struggles
    - ☐ Very Poor
    - ☐ Good
    - ☐ Poor

12. Do you often struggle to fall asleep?
    - ☐ Yes
    - ☐ No

13. Do you often struggle to sleep through the night?
    - ☐ Yes
    - ☐ No

Dietary

14. What type of diet do you follow (ie: macrobiotic, reduced calories, vegetarian, none)?

15. How many cups (8oz. / half pint) of water do you drink per day? (Not as part of other drinks.)

16. What kind of water do you mostly drink?

- ☐ Tap
- ☐ Filtered
- ☐ Distilled
- ☐ Alkaline
- ☐ I regularly drink more than 1 of these
- ☐ Other

17. How many cups (8oz. /half pint) of caffeinated coffee or tea do you drink per day?

18. How many cans (12oz. or ¾ pint) of soda do you drink per week?

19. How many cups (8oz. / haf pint) of cow's milk do you drink per week?

20. How often do you drink alcohol (beer /wine /spirits)?

- ☐ Never / almost never
- ☐ A couple times / month
- ☐ A couple times / week
- ☐ At least once / day

21. How many times per day do you eat sugary foods, including sweet cereals, candies, desserts, etc?

- ☐ Never / almost never
- ☐ More than 1 per day
- ☐ 2-3 times per day
- ☐ 4+ times per day

22. Do you usually try to avoid eating highly processed foods?

- ☐ Yes
- ☐ No

23. Do you usually try avoiding artificially flavoured or coloured foods?

- ☐ Yes
- ☐ No

24. Do you usually try to avoid artificial sweeteners?

- ☐ Yes
- ☐ No

25. Do you try to mostly consume organic foods?

- ☐ Yes
- ☐ No

26. Indicate any known food allergies or sensitivities:

27. How often do you eat at restaurants?

- ☐ Never / almost never
- ☐ 1-3 times per month
- ☐ 1-3 times per week
- ☐ Nearly every day, or every day

28. If you eat breakfast, describe your typical breakfast foods.

29. If you eat lunch, describe your typical lunch foods.

30. If you eat dinner, describe your typical dinner foods

31. If you snack, describe your typical snack foods, including desserts.

32. Including both snacks and meals how many times do you typically eat per day?
    ☐ 1 time per day ☐ 2 times per day
    ☐ 3 times per day ☐ 4+ times per day

Health Matters

33. In a typical week how would you rate your AVERAGE health levels (how well you are feeling)?
    Lowest ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Highest

34. In a typical week, how would you rate your AVERAGE energy levels?
    Lowest ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Highest

35. In a typical week, how would you rate your LOWEST energy levels?
    ☐ No fatigue ☐ A little fatigue ☐ Moderate ☐ Strong ☐ Extreme

36. In a typical week, how would you rate your AVERAGE physical pain levels?
    Lowest ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Highest

37. In a typical week, how would you rate your WORST physical pain levels?
    ☐ No pain ☐ Low / subtle ☐ Moderate ☐ Strong ☐ Extreme

38. List your primary health concerns and how long ago they started.

39. List any major life events for you and how long ago they occurred (e.g. loss of a loved one, a major or meaningful change of job or residence, accidents, child birth, that may be relevant to your CURRENT health concerns)

40. List any major health problems/ hospitalizations from the past (including childhood) and how long ago they occurred.

41. Indicate any of the following that you have been medically diagnosed with.
    ☐ Addison's Disease ☐ Hepatitis C

- ☐ Autism
- ☐ Autoimmune Condition
- ☐ Bronchitis
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Fatigue Syndrome
- ☐ Cirrhosis
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Diabetes Type1
- ☐ Diabetes Type2
- ☐ Epilepsy
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Gout
- ☐ Gum Disease
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Huntington's Disease
- ☐ Immune Deficiency
- ☐ Kidney Disease
- ☐ Learning Disorder
- ☐ Liver Disease
- ☐ Lupus
- ☐ Lymphedema
- ☐ Meniere's Disease
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Raynaud's Disease
- ☐ Rheumatoid Arthritis
- ☐ Sinusitis
- ☐ Sjogren's Syndrome
- ☐ Spleen disorder / removal
- ☐ Stroke
- ☐ Thyroid Disorder (Over or Under active)
- ☐ Vascular Disease
- ☐ None of these

42. Indicate any of the following symptoms that you frequently or always have.

- ☐ Acne
- ☐ Asthma
- ☐ Back Pain
- ☐ Bacterial or Viral Infections
- ☐ Bloating
- ☐ Chest pain / tightness
- ☐ Cold hands / feet
- ☐ Cold sores
- ☐ Colds / Flu
- ☐ Constipation
- ☐ Coughing (chronic)
- ☐ Dandruff
- ☐ Diarrhea
- ☐ Digestive Issues
- ☐ Dizziness / Vertigo
- ☐ Dry Mouth
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Palpitations
- ☐ Heartburn
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Joint pain
- ☐ Memory Problems
- ☐ Muscle Pain
- ☐ Nasal Congestion
- ☐ Nasal drip / Excessive Mucus
- ☐ Nausea / Vomiting
- ☐ Neck Pain
- ☐ Physical Coordination Difficulty
- ☐ Shortness of Breath
- ☐ Skin Rashes

- ☐ Ear Infections
- ☐ Eczema
- ☐ Eyes (Bloodshot)
- ☐ Eyes (Watery / Itchy)
- ☐ Fatigue
- ☐ Focus (Trouble Focusing / Concentrating)
- ☐ Fungal Infections
- ☐ Gums (Swollen / Bleeding)
- ☐ Hair Loss (Excessive)
- ☐ Hay Fever
- ☐ Sore Throat
- ☐ Stuttering / Stammering
- ☐ Thirst (Excessive)
- ☐ Tinnitus (Ringing in Ears)
- ☐ Urination (Burning)
- ☐ Urination (Frequent or Urgent)
- ☐ Vision Blurry (glasses unhelpful)
- ☐ Warts
- ☐ Wheezing
- ☐ None of These

43. Indicate any organs or parts of organs that have been removed.
    - ☐ Appendix
    - ☐ Gallbladder
    - ☐ Kidney
    - ☐ Spleen
    - ☐ Stomach
    - ☐ Lung
    - ☐ Colon
    - ☐ Reproductive Organs

44. Have you had an organ transplant?
    - ☐ Yes
    - ☐ No

45. Do you have a pacemaker or any other electrical device supporting your health?
    - ☐ Yes
    - ☐ No

Dental

46. Indicate which statements apply to you.
    - ☐ I see the dentist regularly
    - ☐ I have amalgam (aka “mercury”) or gold fillings.
    - ☐ I have one or more root canals
    - ☐ I have sore or bleeding gums
    - ☐ I have loss of teeth / loose teeth
    - ☐ I have an irregular bite, jaw tension or I grind my teeth
    - ☐ I have mouth ulcers
    - ☐ I have receding gums
    - ☐ None of thse apply

47. On average, throughout a typical week, which of these would you consider to be the dominant or most common feeling that you're aware of?
    - ☐ Happiness / Joy
    - ☐ Sadness / Grief / Depression
    - ☐ Anger / Irritation
    - ☐ Anxiety / Fearfulness
    - ☐ Other

48. How many days in a typical week would you say you feel MOSTLY positive emotions?
    - ☐ almost never MOSTLY positive days
    - ☐ 1-2 days / week
    - ☐ 3-4 days / week
    - ☐ 5-7 days / week

Medication / Supplements

49. List any herbal medicines or nutritional supplements you are presently taking and how long you have been taking them

50. List all medications you are presently taking, the dosage and for how long.

51. Have you had strong reactions to any of the following? If yes, select all that apply.
    - ☐ Nutritional Supplements
    - ☐ Herbal Supplements
    - ☐ Prescribed Medications
    - ☐ Over the Counter Medications
    - ☐ Homeopathy
    - ☐ Energy Healing (e.g. Reiki)

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