Laura Kopec, NDT, MHNE, MA, CNC
www.laurakopec.com
laurakopecwellness@gmail.com/972-649-4207

Client Intake and Health History

Name: _____ Date of Birth: _____ Age: _____

Parent/Guardian (If name above is minor): _____

Mailing Address: _____

City _____State:_____ Zip _____

Best phone number: _____ Email: _____

Emergency Contact: Name: _____Phone:_____

How did you hear about us? _____

LAB WORK (Not necessary for appointment)

Check any lab work you have completed in the past year. **Please submit recent lab work.**

____ IgG, IgE, IgA, or other food allergy testing
____ Comprehensive Digestive Stool Analysis (or other digestive or stool test)
____ NutrEval or One or other Vitamin/Nutritional Analysis
____ CBC (or other routine blood work)
____ 23andme Genetic Information

GOALS/MAIN REASON FOR VISIT: _____

	Current	Past year	Ideal
Weight			

Height: _____ Blood type (if known): _____

MEDICATIONS AND SUPPLEMENTS

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them: ***(It is important to be accurate in this section)***

Medications:	Reason:	Date began:	Dose:	Helps? Yes or No

Supplements:	Reason:	Date began:	Dose:	Helps? Yes or No

Trouble swallowing pills or object to swallowing pills? _____
Please list any surgeries had or are expecting:
_____
_____

ADDITIONAL IMPORTANT HEALTH INFORMATION

How many glasses of water a day? _____
How often drinking milk? _____
How much and how often drinking soda? _____
How often is there a bowel movement and what time of day (Important information)
_____
Consistency (check the one most closely resembling) _____ loose _____ light and fluffy _____ hard and small
Color: _____
Offensive Odor: _____
Does the bowel movement **sink** to the bottom of bowl:_____

ALLERGIES *(Please list any life threatening or severe allergies to drugs or foods that you have)*
1. 3.
2. 4.

Sources and amounts of: (If applicable)
Caffeine: _____
Alcohol: _____
Smoking history and amount: _____

HEALTH HISTORY
Please circle any problems currently experiencing.

headaches	faintness	insomnia	itchy ears	poor memory
constipation	low energy	blurred vision	ear drainage	watery/itchy eyes
hemorrhoids	stuffy nose	earaches	hearing loss	swollen/red eyes
hernia	congestion	ear ringing	dermatitis	dark circles under eyes
bloating	bronchitis	canker sores	eczema	corrective lenses
diarrhea (frequent)	gagging	acne	hives	clinical depression
shortness of breath	arthritis	hair loss	cold sores	frequent sadness
rapid heartbeat	leg cramps	flushing	hyperactive	confusion
high blood pressure	weak or tired	dizziness	restless	ear infections
swollen lymph glands	passing gas	palpitations	mood swings	sinus problems
nausea or vomiting	binge eating	diabetes	anxiety	osteoporosis/osteopenia
ulcers	cravings	nail fungus	irritable	sensitive to noise
acid reflux	belching	genital itch	hypoglycemia	grinding teeth at night
compulsive eating	snoring	discharge	low blood sugar	hyperthyroidism
heartburn	sleep thrashing	asthma	night sweating	hypothyroidism

Any diagnosed illness or condition in the past year? _____ If so, please explain:
_____
_____

WOMEN'S HEALTH (If applicable)
Any gynecological symptoms or problems?_____ If yes, please explain:_____
Chronic yeast infections?_____ If so, how often: _____
If menopausal or perimenopausal: List symptoms and concerns:_____
_____
_____
Periods generally last ___ days and occur every ___ days.
Birth Control Pill:_____ For how long?_____
Bleeding is __ Heavy __ Moderate __ Light
PMSSymptoms_____
_____

LIFESTYLE *(Please answer the following questions to the best of your ability.)*

How many times a week is physical activity? _____
What time is bedtime? _____ How long before asleep? _____
List any sleep issues or concerns: _____
How often is eating after dark and if so, what foods?
_____
What foods are being craved or cannot be lived without? _____
What is weekly grocery bill? _____
How many times a week is restaurant food being eaten? _____
How many times a week is fast food being eaten?_____

True of False (Circle any that apply)

I have a short attention span	I am inflexible and may appear selfish	I focus on the negative	I often feel dissatisfied or bored

I lack clear goals or forward thinking	I get upset when things do not go my way	I have poor sleep and poor appetite	I avoid conflict
I am impulsive	I hold a grudge	I am depressed	I am shy or timid often
I am disorganized	I am obsessive	I am irritable often	I often misread incoming information
I procrastinate	I am argumentative	I have low energy	I experience anxiety or panic attacks
I fail to give close attention to detail	I get upset when things are out of place	I feel isolated and socially disconnected	I have excessive fear of being judged by others
I have trouble learning from mistakes	I have an intense dislike for change	I have low self esteem	I experience muscle tension
I have a tendency to lose things	I am often indifferent	I have little interest in activities that are usually fun	I freeze in anxiety situations
I am easily distracted	I lack motivation	I have feelings of worthlessness	I seek excitement
I worry	I have a poor memory	I have crying spells	I have attention problems
I have low libido	I have trouble finding the right word	I have mood swings	I have hopeless or dark thoughts
I bite fingernails or pick my skin	I cannot stop working	I have anxiety for little or no reason	I am aggressive toward myself or others
I get stuck on negative thoughts or behaviors	I have a difficult temperament	I suffer from PMS	

What is the primary source of stress? _____

Please list what has been eaten either past three days, or any three days if typical

Day 1	Day 2	Day 3
Breakfast:	Breakfast:	Breakfast:
Lunch:	Lunch:	Lunch:
Dinner:	Dinner:	Dinner:
Snacks:	Snacks:	Snacks:
Water Intake:	Water Intake:	Water Intake:

I have read, understood and completed this confidential questionnaire voluntarily. I take full responsibility for any information I have withheld. Any questions I answered were to my satisfaction. I understand that I may choose to change my child's and my family's eating and lifestyle habits based on the information provided. I am voluntarily receiving information and take full responsibility of any risks due to the changes I may choose to make for my child's health. I understand that I should acquire medical advice from a doctor and I will not use the information provided to treat my own illness. I agree to waive any claim or right to sue as a result of the information provided. I understand it is my responsibility to have my physician's approval if I so desire before changing my child's diet. By signing this agreement, I understand I will be charged for services I receive, products I order and appointments I no-show.

Client or Parent Signature: _____

Authorization and Consent for Nutritional Program

Please initial and sign at the bottom of this form.

_____**Payment is expected at the time of service.** We do not accept insurance of any kind. You must pursue reimbursement independently. We cannot guarantee any outcomes related to filing your own claim.

_____**Scheduling:** Laura keeps her fees affordable as part of her gift to helping you to take charge of your health, she asks in return that you are respectful of her time and properly cancel or reschedule an appointment. Please reschedule or cancel your appointment at least 24hrs in advance.

_____ If you fail to provide 24 hours notice to cancel an appointment for any reason, there is a $25 no show fee automatically charged to you.

I, _____, understand that I am being provided information and not medical advice, and it is my choice whether or not to change my eating and lifestyle habits or those of my family.

I, _____, understand that is my responsibility to obtain specific medical advice from a medical doctor.

I, _____, understand the information provided and anything I learn is not intended to diagnose any disease or condition.

I, _____, understand it is my responsibility and choice to have or not have my physician's approval before changing my diet and/or my dependents.

I, _____, take full responsibility of any changes in my (and my dependents) eating and lifestyle habits I choose to make.

I, _____, understand that in exchange for the educational information I receive in my appointment, I agree to notify the office if I experience any adverse effects from any of the changes I make in my diet and supplements. If I fail to notify the office within a reasonable time of the onset of such unexpected adverse effects, I agree any claim that I may have resulting from such adverse effects will be barred, waived and released.

I, _____, agree to waive any claim or right to sue as a result of the information and guidance I receive.

I, _____, further make a binding promise to give full disclosure of medications and supplements currently taking or in the future for the safety of potential risks involved in combining supplements or medications.

I, _____, understand that I may discontinue accepting services of Laura Kopec and Kopec Wellness, LLC at any time. This withdraw does not revoke this consent form. The consent form remains applicable to any information and services provided prior to discontinuing services.

By completing and submitting this form, I agree I have read and fully understand the above information, the elements of my informed consent, my rights and responsibilities, and hereby give consent to Laura Kopec/Kopec Wellness, LLC and the services and products provided by the professionals employed.

Signature: _____Printed Name: _____
Date:_____