Abitare Health

Live in Health. Embody Wellness. Inhabit Vitality.

Michelle Enmark, DDS, BCHN (Cand.)

931 Howe Avenue, Suite B

Sacramento, CA 95825

(916)922-2115

CLIENT INTAKE FORM

Name____

Address____

City___________________________________State_______________Zip Code______________

Phone (cell) _________________________________ (work) ____________________________________

Email____

Who may we thank for referring you? ____

How do you prefer to be notified of upcoming appointments? (circle one) VM /EMAIL /TEXT

I consent to receive appointment confirmation, periodic newsletters, and pricing specials. YES / NO

What has brought you in to see us? Please list your top three health concerns, if any, and your top three health goals____
____
____
____
____
____
____

When did you first experience these concerns? ____
____
____

Have you dealt with these concerns in the past? Y / N If so, what has worked/not worked?____

____
____

Age______________Birthdate____________________________ Gender___________________

Height____________Current weight_________Weight one year ago_______Ideal weight_______

Birth weight if known_____________Traditional birth or C-Section? (circle one) Breast fed? Y /N

If yes, how long? ________________ Ancestry(i.e. Northern European, Native American, etc)____

What was your diet like as a child?____
____
____

Please list all major childhood diseases/hospitalizations____
____

Please list all health conditions for which you have received a diagnosis____
____
____

Are you currently under the care of a physician? Y / N

If yes, please provide contact information____

____

How many times have you had a course of antibiotics in your life? ____________<5 _____________5-10 ________________>10

Are you or have you ever been a cigarette, pipe, cigar smoker or chewed tobacco? ___________

How many times have you been sick (cold, flu, anything else) in the past year? ________

Please list all medications and supplements that you are currently taking____
____
____
____
____

Do you have any known food allergies? ____wheat____eggs____shellfish____soy____nuts____other. Please explain.____

How would you rate your levels of satisfaction/happiness in the following areas, on a scale of 1-10, with ten indicating an extremely high level of satisfaction/happiness?

Family____________ Career________________ Financial________________

Relationships______________ Health________________ Other (describe) ______________

What do you do to relieve stress?
____
____

How well do your stress relief methods work for you? ____

On a scale of 1-10, how important to you is exercise/movement?______

What forms of movement/exercise do you enjoy/practice?(check all that apply)

____walking ______running ____cycling ______martial arts ______yoga ______pilates ______zumba

______free weights ______calisthenics ______machines at gym ______kayaking ______hiking______soccer

______cross fit ______tennis ______basketball ______swimming ______volleyball ______golf

______gardening ____other

On a scale of 0-10, where 0 is never/least and 10 is always/most, please rate the following:

Constipation______ Diarrhea______Use laxatives frequently_____Lower abdominal pain relieved by passing gas or stool______Gas is frequently foul smelling______Hard or small stool_______

Frequent bloating and distension after eating______Unpredictable food reactions_________Food reactions increasing in severity________Food reactions increasing in number_________Aches, pains, swelling throughout the body_____

Intolerance to smells______Intolerance to jewelry_______Intolerance to perfume, shampoo, detergents, etc.______Skin outbreaks_________

Gas or stomach ache immediately after a meal______Undigested food found in stool_______Excessive burping_______Sense of fullness and food "just sitting there" after a meal_________

Temporary relief by using antacids, carbonated beverages or milk_______Stomach pain, burning or aching 1-2 hours after eating______Heartburn when lying down________Heartburn due to spicy foods, chocolate, citrus, alcohol, caffeine_______________

Indigestion 2-4 hours after eating_________Nausea and/or vomiting_________Frequent loss of appetite_________Excessive passage of gas_________Difficulty digesting fiber_____________

Abdominal distension/gas after consumption of fiber, starches, sugar__________Frequent use of antacid medication___________Abdominal distension after taking certain supplements___________
Constipation___________Diarrhea____________

Greasy or high fat food cause GI Issues________Lower bowel gas/bloating several hours after eating__________Gall bladder attacks____________Yellowish cast to eyes_________Reddened skin, especially palms_________Dry or flaky skin or scalp__________Bitter, metallic taste in mouth_______

Acne_______Excessive hair loss________Bloating_________Swelling for no reason_________Weight gain_______Foul-smelling sweat/body odor_______Hormone imbalances_________

Crave sweets_______Irritable if meals are missed________Depend on coffee to get going________Lightheaded if meals are missed_________Eating relieves fatigue_________Blurred vision__________Poor memory__________

Fatigue after meals_________Crave sweets_________Must have sweets after meals________Frequent urination_________Increased thirst___________Difficulty losing weight_________

Cannot stay asleep_________Crave salt___________Afternoon fatigue_________Dizziness when standing up quickly___________Afternoon headaches_________Weak nails__________ Stress headaches__________

Cannot fall asleep_________Perspires easily__________Wake up tired even after 6+ hours of sleep________Under a high amount of stress___________Weight gain when under stress_________

Edema and swelling in ankles and wrists__________Muscle cramping_________Abnormal sweating from minimal activity__________Inability to hold breath for very long__________Cold hands/feet_________
Gains weight easily_________Outer third of eyebrow thinning_________Excessive hair loss_________Mental sluggishness__________Infrequent bowel movements___________

Heart palpitations_________Inward trembling_________Nervous and emotional_________Insomnia_________Night sweats not due to menopause_________Difficulty gaining weight_________

Males only:

Difficulty urinating_________Pain inside of legs or heels________Leg twitching at night_________

Decreased libido_________Decreased fullness of erections_________Inability to concentrate_________
episodes of depression__________Increase in fat distribution around chest and hips__________More emotional than in the past_________

Menstruating Females only:

Perimenopausal symptoms_________Irregular menstrual cycles__________Pain and cramping_________
Heavy or light blood flow__________Pelvic pain during menses___________Acne around certain times of the month only___________PMS_________Facial hair growth_________

Menopausal Females only:

Hot flashes___________Mood swings__________Decreased libido___________Mental fogginess____________Depression___________Vaginal dryness____________Shrinking breasts__________Facial hair growth____________Acne___________Night sweats___________

What percentage of your meals are home-cooked? ___________________

How much water do you drink per day? _________________

Which of the following foods do you consume regularly (at least four times per week)?

Soda-diet or regular_________ Fruit Juices___________ Coffee____________ Alcohol_________

Starchy sugary treats (pastries, pie, cake, cookies, etc) _________ Fast food__________

Sugary treats (candy, gum, mints) ___________ Dairy____________ Gluten (wheat, barley, rye) _______

Seafood_________ Sports drinks (Gatorade, PowerAde) __________ Green vegetables_____________

Are you/have you ever been on a specialized eating plan? (Check all that apply)

Paleo__________ Dairy free________ Raw foods___________ Vegan__________

Vegetarian___________ Low carb__________ Low sugar__________ Gluten-free__________

Blood Type___________ Mediterranean_____________ Low fat____________ Other:____________

How did you feel while on the plan? ____

____

Rate on a scale of 0(not willing) to 10(very willing):

In order to improve your health, are you willing to:

Significantly modify your diet__________ Keep a record of everything you eat for a period of time___________ Take several nutritional supplements____________ Modify your lifestyle________ Practice a relaxation technique___________ Engage in regular physical activity__________ Have lab tests periodically to assess your progress__________ Learn and implement new recipes and cooking methods__________ Try new foods and drinks_____________

Thank you for taking the time to fill out this form.

Congratulations on taking this first step toward achieving optimal health and vitality! We look forward to being a part of your wellness journey.

IMPORTANT INFORMATION

Client Informed Consent

I,________________understand that the information provided on the relationship between nutrition, lifestyle and health is **NOT** meant to replace competent medical treatment for any health problems or conditions. Health education and medical care are complementary and integrative when properly delivered.

I,________________choose to improve my health by assuming greater responsibility to reduce or eliminate behaviors that are not supportive of my desired lifestyle and outcome for my health.

I,_________________understand that I must provide a minimum of 48 hours of advanced notice before rescheduling or cancelling an appointment. A charge of $50.00 per hour of scheduled time will be assessed, based on the discretion of Dr. Enmark and Kelly.

I,_________________understand that payment for all services is expected at the time of the appointment. We accept cash, checks, all major credit cards, and offer financing with a healthcare company called CareCredit. Please ask my front office team for more details.

We agree to work together to design and maintain an individualized health and wellness plan based on the gathered findings, practical skills, commitment to the desired outcome, and support.

Signed_______________________ Date______________

Print name________________________

Signed___________________________ Date____________

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