trillium
NATURAL MEDICINE
naturopathic medicine & acupuncture

Bee Westwood, MScN

Initial Intake Form

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone _____

E-Mail _____ Birthday _____

Referred By _____ Occupation _____

Age _____ Height _____ Weight _____ BP _____ (if Available)

What is your main concern // area of interest // goal?

_____

_____

Personal History (Check/Circle all that apply)

Stroke ☐
High Cholesterol ☐
How High? _____
High Blood Pressure ☐
How High? _____
Diabetes ☐
Metabolic Syndrome ☐
Insulin Resistance ☐
Low Blood Sugar ☐
Chronic Fatigue ☐
Arthritis (RA or OA) ☐
Fibromyalgia ☐
Multiple Chemical Sensitivities ☐
Infectious Mononucleosis ☐
Frequent Colds/Flu ☐
Cold Sores ☐
Cancer ☐
What type? _____
Chemo? ☐
Rads? ☐

Thyroid Problems ☐
Hypothyroidism ☐
Hyperthyroidism ☐
Headaches ☐
Chronic Tension ☐
Migraines ☐
Cluster ☐
Hormonal ☐
Sleep Problems ☐
Forgetfulness ☐
Hot Flashes ☐
PMS ☐
Birth Control Pills / Hormones ☐
Weight Problems ☐
Constipation
Diarrhea ☐
Abdominal Cramping ☐
Bloating ☐
Yeast Infections ☐
Low Libido ☐

Food Allergies – to what?

_____
_____
_____

Seasonal Allergies to what?

_____
_____
_____

Medication Allergies – to what?

_____
_____
_____

Other:

_____
_____
_____

When was your last blood work? Please list any abnormal levels:

Please list any medications you are currently taking:

Please list any vitamins and/or herbal supplements that you are currently taking and reason (e.g. calcium – for bone health):

Do you eat, drink, or use (Check/ Circle all that apply)?

Antacids ☐	Protein Drinks ☐	Appetite Suppressants ☐
Aspirin ☐	Alcohol ☐	Coffee ☐
Tylenol ☐	Tap Water ☐	Decaf Coffee ☐
Ibuprofen ☐	Bottled Water ☐	Soda ☐
Laxatives ☐	Tea (caffeine or non) ☐	Refined Sugars ☐
Candy ☐	White Flour Foods ☐	Dairy Foods ☐
Wheat Foods ☐	Fast Foods/Take-out ☐	Chewing Gum ☐
Fried Food ☐	Chips/Similar bagged snacks ☐	Artificial Sweeteners ☐
Tobacco ☐	Cigarettes ☐	Energy Drinks ☐

List any food aversions and/or foods you dislike:

Do you cook regularly? If so, how many days or meals per week? If you do not, are you *able* to cook more regularly?

How many meals do you eat out each week?_____

What are your favorite foods?_____

Do you experience any symptoms after meals?_____

Describe your relationship with food (as specific as possible)

_____

_____

_____

Are you under noticeable amounts of stress? (Y/N) _____
Please rate your stress between 1-5, with 1 being Low Stress & 5 being High Stress:

At home _____ At work/school _____
Physical Stress _____ Mental Stress _____

Exposed to chemicals regularly? (Y/N) _____

If yes, what type of chemical _____

Exposed to smoke regularly? (Y/N) _____

How often do you have bowel movements? _____ per day/week/month(circle/bold/type) _____

Do you have digestive difficulties (i.e., bloating, constipation, gas etc.) _____

How many times do you urinate per day? _____

Do you exercise? Please explain briefly:

_____

_____

Are your nails weak or brittle? _____

Average sleep (hours) per night? _____

What is the quality of your sleep with 1 being POOR to 5 being AMAZING? _____

On a scale of 1-10 with 10 being EXTREMELY, how willing are you to making some changes and commit to achieving better health? _____

What do you hope to achieve through working with a nutritionist?

_____

_____

_____

Is there anything else about your history, current concerns, or goals that you would like to mention?

3 – Day Food Journal

Day 1

	Time	Food	Beverages
Breakfast			
Lunch			
Dinner			
Snacks			

Day 2

	Time	Food	Beverages
Breakfast			
Lunch			

Dinner			
Snacks			

Day 3

	Time	Food	Beverages
Breakfast			
Lunch			
Dinner			
Snacks			