INVESTIGATIVE HEALTH

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NEW CLIENT INTAKE FORM

Please complete this form as thoroughly as you can before your first appointment. The more detail you share, the more clearly we can investigate the root of your concerns. Nothing here is too small — every clue helps. All information is kept private and confidential.

1 · PERSONAL & CONTACT INFORMATION

FULL NAME _____ DATE OF BIRTH _____ AGE _____

OCCUPATION _____ TODAY'S DATE _____

PHONE _____ EMAIL _____

HOW DID YOU HEAR ABOUT INVESTIGATIVE HEALTH?

_____

2 · YOUR HEALTH CONCERNS & GOALS

WHAT BRINGS YOU HERE?

List your main health concerns, most important first. Include when each began and how it has changed over time.

CONCERN / SYMPTOM	WHEN DID IT START?	SEVERITY (1–10)	WHAT MAKES IT BETTER OR WORSE?

YOUR TOP THREE GOALS FOR WORKING TOGETHER

1 _____

2 _____

3 _____

IF WE SOLVED THESE, WHAT WOULD CHANGE IN YOUR DAILY LIFE?

3 · MEDICAL HISTORY

CURRENT OR PAST DIAGNOSES

SURGERIES & HOSPITALIZATIONS (WITH APPROXIMATE DATES)

SIGNIFICANT INJURIES, ACCIDENTS, OR ILLNESSES

OTHER PRACTITIONERS CURRENTLY ON YOUR CARE TEAM

e.g. physician, specialist, chiropractor, therapist, dentist

HEIGHT	CURRENT WEIGHT	WEIGHT 1 YEAR AGO	BLOOD TYPE (IF KNOWN)

4 · FAMILY HEALTH HISTORY

Check any conditions that run in your immediate family and note who (mother, father, sibling, grandparent).

CONDITION	WHO IN THE FAMILY?
Heart disease / high blood pressure	
Diabetes or blood sugar issues	
Cancer (type)	
Autoimmune conditions	
Thyroid conditions	
Digestive / gut conditions	
Mental health (anxiety, depression, etc.)	
Allergies / asthma / eczema	
Neurological conditions	
Other	

5 · MEDICATIONS, SUPPLEMENTS & ALLERGIES

CURRENT MEDICATIONS

MEDICATION	DOSE	REASON / CONDITION

CURRENT SUPPLEMENTS, VITAMINS & HERBS

SUPPLEMENT	DOSE	REASON

KNOWN ALLERGIES OR INTOLERANCES

Medications, foods, environmental — and what reaction you experience.

6 · SYMPTOM REVIEW BY SYSTEM

Check anything you experience regularly (weekly or more), even if it seems unrelated.

GENERAL & ENERGY

- ☐ Fatigue / low energy
- ☐ Afternoon energy crash
- ☐ Trouble waking up
- ☐ Unexplained weight change
- ☐ Fevers / chills
- ☐ Cravings (sugar/salt/carbs)
- ☐ Feeling cold often
- ☐ Night sweats
- ☐ Low appetite

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Headaches / migraines
- ☐ Dizziness
- ☐ Congestion / sinus issues
- ☐ Post-nasal drip
- ☐ Ringing in ears
- ☐ Dry or watery eyes
- ☐ Sore / scratchy throat
- ☐ Teeth grinding
- ☐ Frequent colds

HEART & LUNGS

- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Swelling in hands/feet
- ☐ Cough / wheezing
- ☐ Cold hands & feet

DIGESTION

- ☐ Bloating / gas
- ☐ Heartburn / reflux
- ☐ Nausea
- ☐ Constipation
- ☐ Loose stools / diarrhea
- ☐ Stomach pain / cramping
- ☐ Undigested food in stool
- ☐ Feel full quickly
- ☐ Food sits heavy

SKIN, HAIR & NAILS

- ☐ Acne / breakouts
- ☐ Eczema / rashes
- ☐ Dry or itchy skin
- ☐ Hair thinning / loss
- ☐ Brittle nails
- ☐ Easy bruising

MUSCLES, JOINTS & NERVES

- ☐ Joint pain / stiffness
- ☐ Muscle aches
- ☐ Muscle cramps / twitches
- ☐ Numbness / tingling
- ☐ Weakness
- ☐ Back pain

MOOD, MIND & SLEEP

- ☐ Anxiety / worry
- ☐ Low mood / depression
- ☐ Irritability / mood swings
- ☐ Brain fog
- ☐ Poor memory / focus
- ☐ Trouble falling asleep
- ☐ Waking during the night
- ☐ Unrefreshing sleep
- ☐ Overwhelm

HORMONAL & OTHER

- ☐ Blood sugar swings
- ☐ Low libido
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Frequent infections
- ☐ Slow healing

ANYTHING ELSE YOU'RE NOTICING?

7 · DIGESTIVE HEALTH (A CLOSER LOOK)

BOWEL MOVEMENTS PER DAY/WEEK

TYPICAL BRISTOL TYPE (1–7)

ANY PAIN WITH THEM?

- ☐ Feel fully emptied
- ☐ Straining
- ☐ Urgency
- ☐ Mucus present
- ☐ Blood present
- ☐ Alternating const./loose
- ☐ Foul odor
- ☐ Floating stools

WHEN DID YOUR DIGESTION LAST FEEL "NORMAL"? WHAT CHANGED AROUND THEN?

HISTORY OF ANTIBIOTICS, FOOD POISONING, OR MAJOR GUT EVENTS

8 · DIET & NUTRITION

WATER PER DAY

CAFFEINE (TYPE & AMOUNT)

ALCOHOL PER WEEK

ANY EATING PATTERN YOU FOLLOW?

- ☐ Omnivore
- ☐ Vegetarian
- ☐ Vegan
- ☐ Pescatarian
- ☐ Gluten-free
- ☐ Dairy-free
- ☐ Paleo
- ☐ Keto / low-carb
- ☐ Low-FODMAP
- ☐ Intermittent fasting
- ☐ No set pattern
- ☐ Other

FOODS YOU CRAVE, AVOID, OR REACT TO

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH FOOD AND EATING HABITS?

e.g. eat on the go, skip meals, emotional eating, eat late at night, restrict

9 · LIFESTYLE, SLEEP & STRESS

AVERAGE HOURS OF SLEEP

BEDTIME / WAKE TIME

SLEEP QUALITY (1–10)

EXERCISE TYPE & FREQUENCY

ENERGY LEVEL (1–10)

CURRENT STRESS LEVEL

Low 1 2 3 4 5 6 7 8 9 10 High

MAIN SOURCES OF STRESS RIGHT NOW

WHAT DO YOU DO TO REST, RELAX, OR RECHARGE?

TOBACCO / NICOTINE USE

RECREATIONAL SUBSTANCES

10 · HORMONAL & REPRODUCTIVE HEALTH

Complete the parts that apply to you.

CYCLE LENGTH / REGULARITY

FIRST DAY OF LAST PERIOD

NUMBER OF PREGNANCIES

- ☐ PMS
- ☐ Painful periods
- ☐ Heavy bleeding
- ☐ Irregular cycles
- ☐ Hot flashes
- ☐ Perimenopause
- ☐ Menopause
- ☐ Low libido

BIRTH CONTROL OR HORMONE THERAPY (TYPE, HOW LONG)

BIRTHS & PREGNANCY HISTORY

If you have children, list each one. Include the year and the type of birth — vaginal, medicated or unmedicated, induced, assisted (forceps/vacuum), planned C-section, or emergency C-section — plus anything notable about the pregnancy, delivery, or recovery.

CHILD	YEAR OF BIRTH	TYPE OF BIRTH	COMPLICATIONS, RECOVERY, OR ANYTHING NOTABLE
1			
2			
3			
4			

DID YOU BREASTFEED? FOR HOW LONG, AND HOW DID IT GO?

ANY MISCARRIAGE, PREGNANCY LOSS, OR FERTILITY DIFFICULTY YOU'D LIKE ME TO KNOW ABOUT?

Only if you're comfortable sharing. Leave blank if you'd rather talk about it in person.

11 · ENVIRONMENT & EXPOSURES

- ☐ Known mold exposure
- ☐ New home / renovation
- ☐ Smoker in household
- ☐ Well / unfiltered water
- ☐ Frequent travel
- ☐ High screen time
- ☐ Work with chemicals
- ☐ Pets in home
- ☐ Sensitive to smells/products

HOUSEHOLD & PERSONAL CARE PRODUCTS YOU USE (CLEANING, SKINCARE, ETC.)

12 · YOUR HEALTH TIMELINE

YOUR OWN BIRTH & EARLIEST MONTHS

How you arrived and how you were fed shapes the gut microbiome from day one, so this is genuinely useful background. Fill in whatever you know — parents and baby books are often the best source.

HOW WERE YOU BORN? (VAGINAL, PLANNED C-SECTION, EMERGENCY C-SECTION, ASSISTED, INDUCED)

FULL TERM?

WERE YOU BREASTFED, FORMULA FED, OR BOTH? FOR HOW LONG?

BIRTH WEIGHT (IF KNOWN)

ANY HEALTH COMPLICATIONS AT BIRTH OR IN YOUR FIRST YEAR?

e.g. NICU stay, jaundice, colic, reflux, feeding difficulty, early antibiotics, recurrent ear infections, food reactions.

THE BIGGER PICTURE

Map the major moments — births, illnesses, injuries, big stressors, moves, diagnoses. Often the story hides in the timing.

YEAR / AGE	EVENT (HEALTH, LIFE, OR EMOTIONAL)

SIGNIFICANT STRESS, LOSS, OR TRAUMA — ENTIRELY OPTIONAL

Difficult experiences leave a physical footprint, and knowing roughly when something happened often explains when symptoms began. Share only what you're comfortable putting on paper — a year and a single word is plenty, and leaving this blank is completely fine. We can talk through anything you'd rather say out loud. This stays private and confidential.

YEAR / AGE	WHAT HAPPENED (AS MUCH OR AS LITTLE AS YOU LIKE)	HOW IT STILL AFFECTS YOU, IF IT DOES

ARE YOU CURRENTLY WORKING WITH A THERAPIST OR COUNSELOR? (OPTIONAL)

13 · READINESS & FINAL THOUGHTS

WHAT HAVE YOU ALREADY TRIED FOR THESE CONCERNS? WHAT HELPED, WHAT DIDN'T?

ON A SCALE OF 1–10, HOW READY ARE YOU TO MAKE CHANGES TO FOOD AND LIFESTYLE?

Not yet [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] All in

WHAT MIGHT GET IN THE WAY, AND WHAT SUPPORT HELPS YOU FOLLOW THROUGH?

ANYTHING ELSE YOU'D LIKE ME TO KNOW?

Acknowledgment. I understand that Kristin Brust and Investigative Health provide functional nutrition and holistic wellness education and support, which is not a substitute for medical care, diagnosis, or treatment, and does not replace the advice of my physician or other licensed healthcare provider. I confirm the information above is accurate and complete to the best of my knowledge.

SIGNATURE _____ DATE _____