Restoring your health. Revitalizing your life.

SHAPE ReClaimed Intake Form

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Sex: ☐ Male ☐Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____

Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Names and ages of children: _____

How did you hear about the SHAPE ReClaimed program? _____

What health benefits do you want to achieve with the SHAPE ReClaimed program?

☐ Improved eating habits ☐ Improved well-being ☐ Decreased inflammation ☐ Weight reduction

☐ Increased energy ☐ Improved sleep ☐ Increased stamina ☐ Other _____

Physical Health

Height: _____ Weight: _____

Are there any areas of your body that are not functioning optimally? ☐ No ☐ Yes

If yes, what forms for stretching do you perform? _____

On average, how many hours do you sleep per night? ☐ <5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you wake up feeling refreshed? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes

If yes, why and when: _____

Have you been diagnosed with any clinical condition or disease? ☐ No ☐ Yes

If yes, what: _____

Have you ever been in a motor vehicle accident? ☐ No ☐ Yes

If yes, what kind and when: _____

Were you evaluated and treated after each accident? ☐ No ☐ Yes

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes

If yes, please explain: _____

Have you had any imaging performed in the last year? ☐ No ☐ X-ray ☐ MRI ☐ US ☐ PET

Have you had blood work performed in the last year? ☐ No ☐ Yes

Were your test results in medically normal ranges? ☐ No ☐ Yes

If not, which results were abnormal? _____

Mental/Emotional Health

Rate the current level of **personal stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **relationship stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **health stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **family stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **occupational stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

How do you manage the stress in your life? _____

Chemical Health

Do you choose to get annual flu shots? ☐ No ☐ Yes

Have you used antibiotics in the last year? ☐ No ☐ Yes

How many cups of water do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of coffee/energy drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of juice/soda/sports drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods)? ☐ No ☐ Yes

If yes, how many servings per day? _____

Do you eat refined sugar? ☐ No ☐ Yes

If yes, how many servings per day? _____

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum)? ☐ No ☐ Yes

Do you have any food/drink allergies, sensitivities or intolerances? ☐ No ☐ Yes: _____

Do you smoke? ☐ No ☐ Yes ☐ I used it for: _____ years

Are you/have you been exposed to second-hand smoke? ☐ No ☐ Yes

Do you take probiotics? ☐ No ☐ Yes

Do you take Vitamin D? ☐ No ☐ Yes

Do you take Omega-3? ☐ No ☐ Yes

Other supplements or homeopathics: _____

Please list any medications that you take regularly and why: _____

_____

_____

Food Health

Please list the foods you commonly eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many cups of vegetables do you eat per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

What foods do you crave? _____

Please state specifically what your goals are with this program: _____

_____

I _____, hereby grant permission to receive a professional and complete physical examination and consultation, including urinalysis and evaluation.

_____ _____

Patient Signature Date

Reviewed December 2018

Inflammation Questionnaire

Patient Name: _____ Date: _____

Point scale: 0 = Never or almost never have symptoms; 1 = Sometimes have the symptom; 2 = Often have the symptom

Symptom	0	1	2	Symptom	0	1	2	Symptom	0	1	2
Anger, irritability				Tired after eating				Restless legs			
Brittle nails				Ulcers				Swelling, edema			
Gallbladder problems				Acne				Urinary tract problems			
Gout				Asthma				Blurred or tunnel vision			
Headaches, migraines				Bronchitis				Body odor			
Muscle cramps, spasms				Chest congestion				Brown "age/liver" spots			
Muscle pain, aches, weakness				Chronic coughing				Cravings			
Tendonitis, bursitis				Constant sneezing				Cysts, boils			
Anxiety				Constipation				Difficulty concentrating			
Bleed or bruise easily				Diarrhea				Difficulty falling/staying asleep			
Chemical sensitivities				Difficulty breathing				Difficulty losing weight			
Chest pain or pressure				Eczema, psoriasis				Excessive sweating			
Depression				Frequent need to clear throat				Fatigue, low energy			
Dizziness, faintness				Hay fever, seasonal allergies				Frequent colds or flus			
Heart disease				Hives				Mood swings			
High blood pressure				Itchy skin, dermatitis				Overweight			
Hot/cold intolerance				Skin rashes				Poor memory			
Hyperactivity				Shortness of breath				Swollen lymph nodes			
Insomnia				Sinus congestion or infection				Swollen tongue, gums or lips			
Irregular or skipped heartbeat				Sore throat, hoarsenes				Swollen, red, or sticky eyelids			
Rapid or pounding heartbeat				Stiffness, limited movement				Vaccine reactions			
Thyroid imbalances				Stuffy nose				Watery or itchy eyes			
Acid reflux, heartburn				Arthritis				Yeast infections			
Cold/canker sores				Bags or dark circles under eyes							
Diabetes				Ear drainage				**Women Only:**			
Belching, passing gas				Earaches, ear infections				PMS			
Bloating				Hair loss or thinning				Breast masses or fibroids			
Food sensitivities/allergies				Incontinence				Irregular periods			
Low blood sugar, hypoglycemia				Infertility				Painful or heavy periods			
Indigestion				Itchy ears				Vaginal discharge			
Insulin resistance				Joint pain				**Men Only:**			
Intestinal or stomach pain				Kidney stones				Erectile dysfunction			
Irritable when hungry				Low back pain				Prostate problems			
Nausea, vomiting				Low blood pressure							
Tinnitus, hearing loss				Low libido				**Total:**			

OFFICE USE ONLY
DATE: _____
[ ] HA TODAY
[ ] HA PHASE II
[ ] CURRENT HA NC PROT.

SHAPE ReClaimed Questionnaire

Patient: _____ Age: _____ M / F: Menstruating/Menopausal/Pregnant

Medication List	Do you want to get off this medication?	OFFICE USE ONLY	
		Date/Amt of Reduction	Or Elimination
	YES NO		
	YES NO		
	YES NO		
	YES NO		
	YES NO		
	YES NO		

Have you been formally diagnosed by a physician with Diabetes or Insulin Resistance? YES NO

Do you have a history of any of the following? Circle those that apply.

Gall Stones	Gall Bladder Attacks	Gall Bladder Surgery	Skin issues: psoriasis, eczema, rashes, fungus
Headaches	Constipation	Belching/Indigestion	Pain in shoulders, hips, side of body
Anger	Knee Issues	Ear/Eyes Issues	Muscle tightness, cramping, spasms

Are you currently undergoing any of the following cancer treatments?

Chemotherapy	Radiation	Trial Drugs

What are your main reason(s) for doing SHAPE ReClaimed?

1. _____
2. _____
3. _____

What things *can't* you do due to Pain/Inflammation/ Weight that you wish you could?

1. _____
2. _____
3. _____

If you are doing SHAPE ReClaimed for weight reduction, what are your short & long term goals?

SHORT TERM:	**LONG TERM:**

Food Habits

Do you mostly cook at home or do you mostly eat out?	COOK EAT OUT
Are you comfortable cooking in the kitchen?	YES NO
Do you rely on recipes for cooking or do you get creative?	RECIPES CREATIVE
Are you an emotional eater?	YES NO
If yes, what emotion causes you to eat:	ANGER SADNESS HAPPINESS GRIEF ANXIETY DEPRESSION OTHER
Do you eat out of boredom?	YES NO
What food is your favorite/your weakness?	_____

INFORMED CONSENT: I understand that if I am on any medications, I have been advised to consult my prescribing physician in regards to dosage reduction and/or elimination of my medication(s) as my physiology changes while on the SHAPE ReClaimed program. I also agree to remain compliant with the guidelines of the program. If I stray from the requirements and outlined recommendations, I understand that results are not guaranteed and that continued purchase of the SHAPE ReClaimed supplement will not be allowed per _____(physician name)_____ and SHAPE ReClaimed.

Signature: _____ Date: _____