

NEW CLIENT INTAKE QUESTIONNAIRE

Name _____ Date _____

Check any questions which are a YES response.

1. Do you have digestive issues? Constipation, gas, belching, etc.
2. Do certain foods aggravate your body? Do you suspect food allergies or sensitivities?
3. How often have you used antibiotics in the last three years?
4. Have you ever injured your head?
5. Do you have mercury amalgams? How many?
6. Are you exposed to mold regularly?
7. Do you constantly battle viruses?
8. Have you had metal exposure in your occupation?