



Heather DeGeorge, Health & Wellness

phone: 630-687-1200 • www.heatherdegeorge.com • fax: 888-826-1620

Compatibility Evaluation Intake Form

My ability to determine whether I am the most appropriate resource to help you on your journey to wellness and what would be required to do so depends on your ability to comprehensively, thoughtfully and accurately complete this Intake Form. My practice seeks to find the root cause of problems; and those can be hidden in the details that don't seem to be related. Please answer every question. If you feel it's irrelevant, we can discuss this when we talk. If you need more room, please use the page at the end and make sure to label your answers.

Today's date:

Contact

Name:

Address:

City:

State:

Zip:

Phone: (note preference for voice messages with an asterisk *)

day:

cell:

night:

e-mail:

Referred by:

Statistics

Age:

Current weight:

Birthdate:

Ideal weight:

Gender:

Weight one year ago:

Height:

Birth weight (if known):

Blood type:

Place of birth:

Family/living situation:

What is your race (if known)?

What is your culture or ethnicity (or the one you most identify with?)

Marital status:

Children (name/gender/age):

Pets (number and type):

Occupation:

Hours per week of work:

Exercise routine (if any—type, duration & frequency):

What do you do to relax?



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History

Have you ever lived or traveled outside of the United States?

If so, when and where?

Have you or your family recently experienced any major life changes?

If so, please explain including dates:

Have you experienced any major losses in life?

If so, please explain including dates:

How much time have you had to take off from work or school in the last year?

0 to 2 days

>15 days

3 to 14 days

Have you ever been hospitalized?

If yes, please explain including dates:

Have you ever had any major illness, infection or injuries?

If yes, please explain including dates:

How is/was the health of your mother?

How is/was the health of your father?

Do your parents or siblings have any allergies?

If yes, please list relative and allergy:



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Health Concerns

What are your main health concerns? *Describe in detail, including the severity of the symptoms:*

When did you first experience these concerns?

How have you dealt with these concerns in the past? doctors self-care

Have you experienced any success with these approaches?

Have any other family members had similar problems? *If yes, please explain:*

Do you have any pain, stiffness or swelling?

If yes, please explain where, how often and strength:

What other health practitioners are you currently seeing? (Include any healers, helpers or therapists. Please include name, specialty and phone number)

Please list any medications your are taking including dosage and frequency:

Please list any vitamins, minerals, herbs or nutritional supplements your are taking including brand, dosage and frequency:

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Nutritional status

Are there any foods that you avoid because of the way they make you feel?

If yes, please name the food and the symptom:

Do you have symptoms immediately after eating—like bloating, gas, sneezing, or hives?

If so, please explain:

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc.? *If so, please explain:*

Are there foods that you crave?

If so, please explain:

Describe your diet at the onset of your health concerns:

Do you have any known food allergies or sensitivities?

If yes, please explain:

Do you have relatives that share these allergies or sensitivities?

If yes, please explain:

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Which of the following foods do you consume regularly?

- | | |
|---------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> soda | <input type="checkbox"/> fast food |
| <input type="checkbox"/> diet soda | <input type="checkbox"/> gluten (wheat, rye, barley) |
| <input type="checkbox"/> refined sugar | <input type="checkbox"/> dairy (milk, cheese, yogurt) |
| <input type="checkbox"/> alcohol (any kind) | <input type="checkbox"/> coffee |

Are you currently on a special diet?

- | | |
|------------------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> ovo-lacto / vegetarian | <input type="checkbox"/> vegan |
| <input type="checkbox"/> diabetic | <input type="checkbox"/> raw |
| <input type="checkbox"/> dairy-free (or restricted dairy) | <input type="checkbox"/> sugar-free |
| <input type="checkbox"/> gluten-free | <input type="checkbox"/> paleo |
| <input type="checkbox"/> blood type | <input type="checkbox"/> GAPS |
| <input type="checkbox"/> other (<i>please describe</i>): | |

Are there foods that you generally don't for reasons that have nothing to do with health?

If so, list the foods and explain why you choose not to eat them:

What percentage of your meals are cooked at home?

Who does the cooking at your home?

Where do you get the rest of your food from?

Is there anything else we should know about your current diet, history or relationship with food?

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Intestinal status

Please take a moment to provide input on your bowel movements.

Frequency: more than 3x/day 1-3x/day not regularly every day

Consistency

- | | | |
|--------------------|--------------------------|-------------------------------------------------------------|
| soft & well-formed | <input type="checkbox"/> | <input type="checkbox"/> thin, long or narrow |
| often float | <input type="checkbox"/> | <input type="checkbox"/> small and hard |
| difficult to pass | <input type="checkbox"/> | <input type="checkbox"/> loose but not watery |
| diarrhea | <input type="checkbox"/> | <input type="checkbox"/> alternating between hard and loose |

Color

- | | | |
|--------------------|--------------------------|-------------------------------------------------------------|
| medium brown | <input type="checkbox"/> | <input type="checkbox"/> variable |
| very dark or black | <input type="checkbox"/> | <input type="checkbox"/> yellow, light brown |
| greenish | <input type="checkbox"/> | <input type="checkbox"/> chalky colored |
| diarrhea | <input type="checkbox"/> | <input type="checkbox"/> alternating between hard and loose |
| blood is visible | <input type="checkbox"/> | <input type="checkbox"/> greasy, shiny |

Do you experience intestinal gas? *If so, please explain if it is excessive, occasional, odorous, etc.)*

Does it take you more than 5 minutes to have a bowel movement?

If so, how often is this the case and does anything affect that?



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Health hazards

Are you regularly exposed to x-ray or ultrasound?

If so, how frequently?

Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

Do odors affect you?

Are you or have you been exposed to second-hand smoke?

Do you have mercury amalgam fillings?

How old is the home you live in?

Where do you get the majority of your drinking water?

Have you used or abused alcohol, drugs, medications, tobacco or caffeine?

If yes, list for each when the abuse occurred and for how long?

Is this still a problem?

How do you handle stress?

Describe your sleep patterns:

Do you fall asleep easily?

Do you stay asleep?

How many hours do you average per night?



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Mental health information

How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

(circle one) 1 2 3 4 5 6 7 8 9 10

At what point in your life did you feel your best? Why?

Other family health information

Have your parents, siblings or children ever been treated for or diagnosed with:

- | | |
|-----------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> cancer | <input type="checkbox"/> cardiovascular problems |
| <input type="checkbox"/> diabetes (Type 1 or Type 2/late onset) | <input type="checkbox"/> liver or gall bladder problems |
| <input type="checkbox"/> asthma or reactive airway disease | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> Crohn's, colitis or IBS | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Alzheimer's or other dementia | <input type="checkbox"/> autism spectrum disorders |

Use this space to detail which relative had which condition:



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Support information

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? *If not, explain:*

Who in your family or on your health care team will be the most supportive of you making nutrition and/or lifestyle changes?

What are your health goals and aspirations?

Take a moment to consider why you might want to achieve those goals and aspirations for yourself:

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For women only

Are/were your menstrual cycles regular?

Do/did you have PMS or PMDD?

If so, please explain:

In the second half of your cycle, do you experience any symptoms of breast tenderness, water retention or irritability?
If yes, please describe:

Are your periods painful?

If so, describe where the pain occurs, it's strength, duration, and when:

Have you experienced any yeast infections or urinary tract infections?

How frequently do/did they occur?

Have you/do you still use birth control?

If so, please list type and length of time taken:

Have you had any problems with conception or pregnancy?

If yes, please explain:

How many times have you been pregnant?

How many live births have you had?

How many miscarriages have you had?

Are you taking any hormone replacement therapy or hormonal supportive herbs?

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If so, please list it here again: