Dr. Patty Barber, ND, ADHP, PSc.D

Phone/Text: (607) 761-8569

Email: DrPattyBarber@gmail.com

Client Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone: (_____)_____ Cell: (_____)_____

Is it ok to leave messages/text on your phone? Yes No

Email: _____

Age: _____ Date of Birth: _____

What was the sex you were assigned at birth? Male Female Unknown Other _____

What gender do you identify as? Male Female Trans Other _____

What are your pronouns? He/Him She/Her They/Them Other _____

How did you hear about us? _____

What are your life goals? _____

What three areas would you like us to begin working on?

_____

_____

Marital Status: Single Married Significant Other Widowed Divorced

Number of Children: _____

How would you describe your family relationship? _____

_____

What long term expectations do you have from working with me? _____

_____

What is your **present level of commitment** to address any underlying causes of your signs & symptoms that relate to your lifestyle & food choices? Rate from 1 to 10, 10 being totally committed) _____

Patricia M. Barber, ND, ADHP, PSc.D **Client Request and Authorization**

I hereby understand as the client that:

I acknowledge that the Nutritional Profile, Evaluation, Energy work and suggested nutritional programs as well as any supplemental materials such as vitamins, minerals, enzymes, Bach flower essences, whole foods and herbs are not for the diagnosis, treatment, cure, alleviation, or prevention or care of any disease of any kind and in any way. I agree that I am totally responsible for obtaining qualified medical assistance for any such services or for the care of any disease or pathological condition. Nevertheless, I reserve the right to use the knowledge I gain from the consultation and follow ups in any legal manner I may choose in the care of my own body. I further declare that the sole reason for requesting the services from Patricia M. Barber, ND, ADHP, PSc.D is for obtaining a suggested nutritional program for the building of my health and wellbeing.

Consultations are limited to education in matters pertaining to the improvement in the overall health and physical fitness for maintenance of the best possible state of physical, mental and emotional health. These subjects may or may not include the examination of urine, saliva, hair or stool. Such procedures are not for the diagnosis or treatment of any health condition or disease. Any procedures including those listed above are at my own choosing.

I am fully aware of the fact that the services being provided to me are spiritually oriented, and that those who counsel me have been educated in an alternative counseling discipline. I realize my God given rights and constitutional rights, which allows me to seek the best care and education for my own personal needs.

I am aware that I am entitled to receive information from my counselors about any method or procedures to be used, fees to be charged and the approximate length of the procedure, if it can be determined by personal experience, testimonies and suggestions.

I am free to obtain a second opinion from another practitioner at any time I feel it is necessary.

I understand that all I provide both written and oral is to be kept confidential, and that information concerning myself can be released to another alternative health practitioner only with my consent, verbal or written.

I hereby grant to my counselors to act on my behalf in matters concerning my health and alternative ways. I authorize them to perform any and all health services for me that I have a right to perform for myself and agree to hold them blameless for any and all such acts.

I am not a representative of a branch of a municipal, state, U.S. Government, The American medical Association or the Federal Drug Administration.

I have read and fully understand the above listed information and I do hereby request that I be allowed to participate in a health consultation program with Patricia M. Barber, ND, ADHP, PSc.D for the following reasons:

_____

_____

_____

I understand that insurance is not accepted by this office and fees for services are collected at time of visit unless other arrangements have been made previously.

I understand that any products purchased from this office are not returnable.

Signature: _____ Date: _____

Witness: _____ Date: _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health? _____

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive** lifestyle habits? _____

_____

What **potential obstacles** do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____

Work

Are you active Military or a US Veteran? Yes No

Employment Status: _____ Occupation: _____

How many hours per day do you work? _____ per week? _____

Do you enjoy your work? Or is it a job that you feel you must do in order to make a living?

_____

How would you describe your relationship with your coworkers_____

_____

Would you describe your job as stressful? Yes No

If so, how do you handle the stress?

_____

Does income meet monthly expenses: _____

What do you **LOVE** to do? _____

Do you make time for rest, relaxation or meditation during the day and/or before bed? How do you relax? _____

Primary Health Concerns

Please list in order of importance for you:

1. _____ 2. _____

3. _____ 4. _____

Are you experiencing pain today? Yes No

If so, what is your level of pain today? (On a scale of 1 to 10, 10 being worst) _____

Are there any traumatic events (surgeries, drug reactions, life trauma) that you feel may have contributed to your health problems?

Please list all former treatments that you have used, both conventional and alternative as well as the degree of effectiveness of each treatment:

Allergies

Do you have any food intolerances or allergies? _____

Do you have any environmental sensitivity? _____

Have you ever been exposed to toxic chemicals, solvents or other possible toxins?

Home Environment

Are your home and work environments well ventilated?	Yes	No
Are your home and work environments excessively	Moist	Dry

Which childhood illnesses have you had? (Please circle)

Rubella (German Measles)	Mumps	Whooping Cough	polio
Chicken pox	Roseola	Scarlet Fever	Asthma
Rheumatic Fever	Other: _____		
Do you use vaccinations?	Yes	No	

Dental

Do you have any root canals?	Yes	No	If yes, how many _____
Do you have any amalgam fillings? Yes	No	If yes, how many _____	

Typical Food Intake:

How many meals do you generally eat each day? _____

Do you prepare your own meals? Yes No

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Liquids _____ Are you thirsty? Yes No

How much water do you drink daily? _____

Source: Tap Bottled Distilled Softened Well If well when was it tested? _____

Do you consume: (Please circle)

Soda	Coffee	Fast Food	Cow Milk	Cow Cheese
Meats	Splenda	Sugar	Aspartame	White Flour
Organic Foods		Raw Fruit	Raw Veggies	

What foods do you crave: Salty Sweet Fatty Foods Breads/Pasta

Do you frequently use any of the following:

Aspirin	Laxatives	Diet Pills	Antacids

Alcohol How much per day or week? _____

Tobacco Form & amt per day? _____

Caffeine Form & amt per day? _____

Do you have any dietary restrictions (religious, vegetarian, vegan, etc?

_____

Are you satisfied with your diet the way it is now? Why/Why Not?

_____

_____

Habits

Main interest and hobbies: _____

Do you exercise? Yes No if yes, how often? _____

Do you smoke? Yes No If yes, how long? _____ How many per day? _____

Years since quitting? _____

Do you use recreational drugs? Yes No

If yes, which ones & how often? _____

Sleep

How many hours of sleep do you get on average? _____

Do you have difficulty falling asleep? Yes No

Do you wake up during the night? Yes No If yes, how often? _____

Do you feel refreshed in the morning Yes No

Digestive Health

How frequently do you move your bowels? _____

Do you experience any of the following:

Loose Stools	Hard Stools	Diarrhea
Difficulty passing stools	Gas	Bloating
Undigested food in the stools	Mucous in the stools	Blood in stools
Heartburn/Reflux	Abdominal Pain	

Do you have your gallbladder? Yes No If no, when was it removed? _____

Do you have your appendix? Yes No If no, when was it removed? _____

Do you have your tonsils? Yes No If no, when was it removed? _____

What surgeries have you had & when?

_____

_____

_____

How frequently have you been treated with antibiotics? _____

Please mark next to the following signs & symptoms that apply to you **(N)**ow or in the **(P)**ast.

Now Past Skin

_____ Dry, rough scaly, itchy skin
_____ Rashes, warts
_____ Moles, cysts
_____ Any of above change size/color
_____ Color changes, ridges, pits, or white spots on nails?

Now Past Skin

_____ Pimples
_____ Loss of Hair
_____ Hives
_____ Scars
_____ Light/dark patches of skin

Now Past Lymphatic, Immune System

_____ Painful lymph nodes
_____ Difficulty stopping bleeding
_____ Bleeding from unusual places
_____ Bruising easily
_____ Wounds heal slowly
_____ Anemia
_____ Swollen glands
_____ Fluid retention

Now Past Endocrine

_____ Unexplained weight gain/loss
_____ Prefers hot weather
_____ Prefers cold weather
_____ Can't stand cold
_____ Can't stand heat
_____ Cold hands & feet
_____ Fatigue-long term
_____ Increased thirst
_____ Increased hunger

Now Past Head

_____ Dizziness
_____ Severe headaches
_____ Seizures, Convulsion
_____ Double vision
_____ Fainting spells

Now Past Ears

_____ Discharge from ears
_____ Hearing problem
_____ Sensitivity to noise
_____ Pain in ears
_____ Ringing in the ears

Now Past Mouth

_____ Sore mouth or throat
_____ Speech difficulties
_____ Bleeding gums
_____ Loss of teeth
_____ Cold sores, blisters

Now Past Throat

_____ Persistent hoarseness
_____ Difficulty swallowing
_____ Recurrent strep throat
_____ Loss of voice
_____ Chronic sore throat or pain

Now Past Respiratory

_____ Unexplained fever
_____ Chest pain when breathing
_____ Wheezing
_____ Difficulty breathing at night
_____ Chest congestion
_____ Dry sweats
_____ Night sweats
_____ Shortness of breath
_____ Daily cough

Now Past Cardiovascular

_____ Chest pain when walking
_____ Chest pain when sitting/lying
_____ Ankle or abdominal swelling
_____ Heart palpitations
_____ Leg vein problems
_____ Leg pain when walking
_____ Numbness/tingling in arm/leg
_____ Heart murmur

Now Past Gastrointestinal

_____ Constipation
_____ Diarrhea
_____ Alternating constipation/diarrhea
_____ Change in bowel movements
_____ Strain to eliminate
_____ Hemorrhoids
_____ Black stools
_____ Stool-yellow, grey, green
_____ Stool-foul odor
_____ # of daily bowel movements
_____ Vomiting blood
_____ Frequent or severe nausea
_____ Heartburn
_____ Trouble swallowing
_____ Excessive belching
_____ Excessive lower bowel gas
_____ Stomach cramps, colic
_____ Abdominal bloat/distension
_____ Anorexia
_____ Bulimia
_____ Stomach/abdominal pain

Now Past Gastrointestinal

_____ Distress from fat/greasy food
_____ Bad breath
_____ Body odor
_____ Indigestion immediately after meals
_____ Bloating 2-3 hrs after meals
_____ Pain 5-6 hrs after eating
_____ Above symptoms worse w/ stress
_____ Nervous/shaky better w eating sweets
_____ Craving sweets or alcohol
_____ Appetite change increase/decrease
_____ Loss of appetite
_____ Insatiable appetite
_____ Weight changes increase/decrease
_____ Diet but failed to lose weight
_____ Eating but fail to gain weight
_____ Overweight
_____ Compulsive eating
_____ Addictive eating
_____ Yellow jaundice
_____ Bad taste in mouth
_____ Intestinal parasites suspected

Have you traveled out of the country recently? _____

Now Past Eyes

_____ Poor eyesight (near/far)
_____ Light hurts eyes
_____ Date of last glaucoma check

Now Past Nose

_____ Nose bleeds
_____ Sinus congestion
_____ Nasal scabs/crusts

Now Past Pituitary

_____ Failing memory
_____ Increased sexual desire
_____ Splitting headaches
_____ High/low sugar tolerance
_____ Abnormal thirst
_____ Ulcers, colitis

Now Past Pituitary

_____ Low blood pressure
_____ Decreased sexual desire
_____ Menstrual disorders
_____ Intestinal bloating
_____ Chunky hips/waist

Now Past Thyroid

_____ Overweight
_____ Difficulty with losing weight
_____ Constipation
_____ Tired upon rising
_____ Easily fatigued
_____ Dry or scaly skin
_____ Chilly/sensitive to cold
_____ Mental slowness

Now Past Thyroid

_____ Decreased appetite
_____ Nervousness
_____ Heart palpitations
_____ Irritable/restless
_____ Increased appetite
_____ Underweight
_____ Flush/gets hot easily
_____ Insomnia

Now Past Adrenals

_____ Easily stressed
_____ Easily/chronically fatigued
_____ Dizziness
_____ Headaches
_____ Hot flashes
_____ Bronzing of the skin
_____ Craves salt
_____ Cold extremities
_____ Decreased urine output
_____ Reduced appetite

Now Past Adrenals

_____ Nails weak, ridged
_____ Tendency to get hives
_____ Rheumatism/arthritis
_____ Poor Circulation
_____ Increased blood pressure
_____ Weak after getting cold
_____ Facial hair for women
_____ Light sensitive
_____ Heart pounds when lying
_____ Frequent cold sweats

Now Past Sympathetic Nervous

_____ Upset from acid foods
_____ Nervousness
_____ Gag easily

Now Past Sympathetic Nervous System

_____ Dry eyes, nose, mouth
_____ Wounds that heal slowly
_____ Very quick mentally

Now Past Parasympathetic Nervous

_____ Joint stiffness on rising
_____ Muscle/leg/toe cramps
_____ Butterflies in the stomach
_____ Digestion rapid
_____ Indigestion after eating
_____ Perspiration scant/absent
_____ Perspires easily/profusely

Now Past Parasympathetic Nervous

_____ Frequent vomiting
_____ Alternating constipation/diarrhea
_____ Pulse slow/regular
_____ Breathing irregular
_____ Poor circulation
_____ Eyelids swollen/puffy

Now Past Central/peripheral Nervous

_____ Loss of balance/fainting
_____ Dizziness regularly
_____ Convulsions(seizures)
_____ Blurred/double vision
_____ Tremors (shaking, trembling)

Now Past Central/peripheral Nervous

_____ Paralysis
_____ Numbness/tingling
_____ Temporary loss of sensation
_____ Lack of strength
_____ Continual headache

Now Past Mental Status

_____ Anxiety
_____ Restlessness
_____ Excessive worry
_____ Depression
_____ Despair/discontent
_____ Suicidal thoughts
_____ Suicidal attempts
_____ Loneliness
_____ Mood swings
_____ Prefer to be with people
_____ Like to be alone
_____ Afraid to be alone
_____ Confidence & secure

Now Past Mental status

_____ Memory difficulties
_____ Mental confusion
_____ Concentration difficulties
_____ Make a lot of mistakes
_____ Shy & timid
_____ Self-critical
_____ Overly critical of others
_____ Lack of self confidence
_____ Jealous and suspicious
_____ Sensitive to noise
_____ Organized and very neat
_____ Affectionate
_____ Powerful & assertive

Now	Past	Musculoskeletal System
_____		One arm or leg shorter
_____		Joint pain/stiffness swelling
_____		Backaches
_____		Burning on soles of feet

Now	Past	Musculoskeletal system
_____		Muscle cramps
_____		Unusual redness of palms
_____		Coughing, sneezing or straining
_____		at stools intensifies back pain

Male

Now	Past	Male Reproductive
_____		Prostate problems
_____		Swelling/lumps/pain in testicles
_____		Discharge from penis
_____		Infertility

Now	Past	Male Reproductive
_____		Painful erection
_____		Difficulty with erection
_____		Premature ejaculation
_____		Difficulty with ejaculation

Female

Now	Past	Female Reproductive
_____		Lumps in breast
_____		Nipple discharge
_____		Breast pain
_____		Pelvic pain
_____		Discharge from vagina
_____		Vaginal itching/burning
_____		Genital eruptions

Now	Past	Female Reproductive
_____		Bleed/spot btwn periods
_____		Painful sex
_____		Lack of sexual desire
_____		Difficulty feeling sexually aroused
_____		Never/seldom have orgasms
_____		Menstruation excessive
_____		Menstruation absent

Please write a short description of yourself: _____

_____

_____

_____

Is there anything else that you believe is important for me to know about you? _____

_____

_____

_____

Signiture: _____