

# Naturally Unbridled Wellness Client Intake

Today's Date \_\_\_\_\_

Name: \_\_\_\_\_  Male  Female  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_  
**FULL** Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_  
Referred by: \_\_\_\_\_

Are you currently nursing or pregnant?  Yes  or  No

List your primary wellness goal(s): \_\_\_\_\_

What are you trying to accomplish with our services?

- |  |  |
|--|--|
| <input type="checkbox"/> Less Pain                       | <input type="checkbox"/> Better Sleep                              |
| <input type="checkbox"/> More Energy                     | <input type="checkbox"/> Improved Mood                             |
| <input type="checkbox"/> Digestive Balancing             | <input type="checkbox"/> Weight Optimization                       |
| <input type="checkbox"/> Emotional Balance               | <input type="checkbox"/> Clearer thinking                          |
| <input type="checkbox"/> Fertility Support               | <input type="checkbox"/> Lyme Disease or Other Infection           |
| <input type="checkbox"/> Autoimmune Disease              | <input type="checkbox"/> Female Hormone Support                    |
| <input type="checkbox"/> Recovery from Illness or Injury | <input type="checkbox"/> Skin Issues (rash, acne, etc.)            |
| <input type="checkbox"/> Allergy Support                 | <input type="checkbox"/> Healthy Diet & Lifestyle Support          |
| <input type="checkbox"/> Urinary Issues (kidney/bladder) | <input type="checkbox"/> Circulatory Issues (Blood pressure, etc.) |
| <input type="checkbox"/> Neurological Support            | <input type="checkbox"/> Cancer Support                            |
| <input type="checkbox"/> Other:                          |  |

Who is your Chiropractor: \_\_\_\_\_

How many OUNCES of WATER do you drink in an average day? \_\_\_\_\_

**Pharmaceuticals** (prescription or over-the-counter) including birth control taken in last two months:

**Vitamins/ Supplements** taken in last two months:

**Vaccines** since the start of the COVID pandemic:

## Check All That Apply

### Digestive

- Constipation with or without straining
- Diarrhea once a month or more
- Bloating with or without passing gas
- Heartburn, Reflux, GERD, EOE, Barret's Esophagus
- Very stinky gas/stool
- Formed, smooth bowel movements most days

- Belching
- Undigested food in stool
- Greasy food goes right through you
- IBS or inconsistent bowels
- Pain under the right rib cage
- Diagnosed with digestive condition

Details:

### Sleep

- Fall asleep easily
- Wake frequently in the night
- Pets or family disturbs sleep
- Medication, supplements, or alcohol needed
- CPAP recommended but not used
- Sleep 7-9 hours and wake rested
- Work requires altered sleep schedule

- Bladder wakes 1 or more times/night
- Can't shut off mind
- Tired upon waking
- Wake and cannot fall back asleep
- CPAP used
- Inconsistent sleep
- Pain disturbs sleep

Details:

### Energy

- Energy is good all day
- Afternoon crash
- Energy drinks or supplements used
- Naps needed
- Second wind late afternoon/evening
- Depression impacts energy level
- Cold hands/feet/generally
- Pain depletes energy
- Tired after eating

- Energy best in the morning
- More than 12 ounces of coffee/day
- Always fatigued
- Night owl
- Not enough energy to exercise
- Exertion wipes me out
- Lightheaded upon standing
- I never stop thinking/working/doing

Details:

### Emotional

- Grief
- Anxiety
- Depression
- OCD
- Panic Attacks
- Worry
- Phobia
- History of trauma/abuse

- Brain fog
- Can't focus
- Embarrassed
- Puts others first constantly
- Angry
- Lack of joy in life
- Lack of support
- Prescription for emotional balance or sleep

Details:

## Metabolic

- |   |   |
|---|---|
| <input type="checkbox"/> Hormone challenges | <input type="checkbox"/> Blood sugar balance                      |
| <input type="checkbox"/> Weight gain        | <input type="checkbox"/> Weight-loss resistance                   |
| <input type="checkbox"/> Panic Attacks      | <input type="checkbox"/> Can't gain weight                        |
| <input type="checkbox"/> Belly fat          | <input type="checkbox"/> Lack of endurance                        |
| <input type="checkbox"/> Neck fat           | <input type="checkbox"/> Prescription for hormones or blood sugar |
| <input type="checkbox"/> Cholesterol        | <input type="checkbox"/> Diabetic or Prediabetic                  |

## Details:

Describe your **exercise** routine:

**Are you looking for natural symptom support or do you want to get to the root cause of the issue?**

## Natural symptom support

## Get to the root cause

**Fertility Clients:** Were you vaccinated for HPV (Gardasil vaccine) or COVID-19:

**How long do you think it will take to reach your wellness goals? \_\_\_\_\_**

**Do you have:**  < Seizure Disorder       < Pacemaker       < Alcoholism

**How willing are you to make lifestyle changes to improve your situation?**

I understand that Patti Bartsch, Ph.D. and the staff at Naturally Unbridled Wellness LLC are not medical professionals; therefore, they do not diagnose, treat, cure, or prescribe for any disease or condition. Their comments are not a replacement for qualified medical care. I have stated any medical conditions that apply to me and I take it upon myself to keep the practitioners and my healthcare providers up to date on health changes. It is my responsibility to evaluate all supplements and remedies for allergies and contraindications.

**CLIENT signature**

date

If you are under 18 years old a guardian must sign this form. Thank You.

You may include any other information that you feel may be helpful to us below: