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**

TOP 2 WELLNESS GOALS

(Why you are here):_____

What are you trying to accomplish with our services?

___Less Pain
___More Energy
___Digestive Balancing
___Emotional Balance
___Fertility Support
___Autoimmune Disease
___Recovery from Illness or Injury
___Allergy Support
___Urinary Issues (kidney/bladder)
___Neurological Support
___Other:

___Better Sleep
___Improved Mood
___Weight Optimization
___Clearer thinking
___Lyme Disease or Other Infection
___Female Hormone Support
___Skin Issues (rash, acne, etc.)
___Healthy Diet & Lifestyle Support
___Circulatory Issues (Blood pressure, etc.)
___Cancer Support

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:

Have you received any of the COVID vaccines? Yes ☐ No ☐

If yes, how many? _____

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

- ☐ Hormone challenges
- ☐ Weight gain
- ☐ Panic Attacks
- ☐ Belly fat
- ☐ Neck fat
- ☐ Cholesterol
- ☐ Blood sugar balance
- ☐ Weight-loss resistance
- ☐ Can't gain weight
- ☐ Lack of endurance
- ☐ Prescription for hormones or blood sugar
- ☐ Diabetic or Prediabetic

Details:

Do you have any food allergies?

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?

◯ Not Willing ◯ Slightly Willing ◯ Willing ◯ Very Willing

You may include any other information that you feel may be helpful to us--as well as any surgical history, including breast implants:

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

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