Vitality Wellness Patient Intake Form

Name: _____ **Age:** _____ **Referred By:** _____ **Date:** _____

Current Concerns (what brings you in today)	• • • • •
Past Surgeries, Car Accidents, Concussions, Notable Injuries etc	• • • • •
Health History: Illness / Diagnosis from GP	• • • • Number of CV19 Vaccinations / Boosters _____
Record Weekly Consumption	• Coffee _____ • Alcohol _____ • THC / Tobacco / Vape _____ • Carbonation / Pop _____ • Recreational Drugs _____ • Other _____
Supplements / Medications Taken Daily	• • • •
Type of Water & Amount Consumed (Brita filter, tap, well etc.)	
Lifestyle: Diet, exercise, sleep, occupation	**Sleep – How long, quality of sleep** **Exercise – How often, preferred type(s)** **Diet – What do you want to work on or us to know?** **Occupation -** **Average Daily Stress Level: NO STRESS 0 1 2 3 4 5 6 7 8 9 10 CONSTANTLY STRESSED**