Monica Sherline, M.S.

Intake Form

Please take time to answer the following questions as accurately as you can. Your information is strictly confidential and will become part of your case record.

Client

First name		Last name			
Street		Unit		City	
State/Province		Zip		Country	
Home phone	(999)999-9999			Mobile phone	(999)999-9999
Email address					
Date of birth	08/14/2025	Gender	Choose an	Relationship status	Choose an ite
Referred by					

Information

Age		Height (in inches)	
Blood Type		Current Weight	
Family/Living Situation		Ideal Weight	
		Weight One Year Ago	
Occupation		Birth Weight (if known)	
		Current Weight	
Exercise and recreation:			

Children	Ages
Name	Age
Name	Age
ame	Age

Siblings	Birth Order
Current Age	What number are you?
Current Age	
Current Age	
Current Age	

Health History

Have you 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 comment.

Have you experienced any major losses in life? If so, please comment.

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

- ○ 0-2 days
- ○ 3-14 days
- ○ More than 15 days

Health Information

Primary health concern? (Describe in detail, including the severity of the symptoms).

When did you first experience these symptoms?

Have you found anything to make your symptoms better or worse? Are there any other related symptoms?

Do you have any secondary health concerns you are looking to have addressed during your consultation? (Describe in detail)

What other health practitioners are you currently seeing? List name and specialty below.

Please list the date and description of any surgical procedures you have had (including cosmetic)..

Surgical Procedure	Date	Description
	08/14/2025	
	08/14/2025	
	08/14/2025	

Additional procedures

How often did you take antibiotics in infancy/childhood, as a teen, and/or as an adult?

List any medicine you are currently taking.

Medicine Name	Dosage	Frequency / Route	Duration	Comments

Additional space

List all vitamins, minerals, herbs and nutritional supplements you are now taking.

Supp Name	Dosage	Frequency / Route	Duration	Comments

Additional space

Have any other family members had similar problems (please describe)?

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?

Which of the following foods do you consume regularly?

☐ Soda
☐ Diet soda
☐ Fast food
☐ Gluten (wheat, rye, barley)
☐ Refined sugar
☐ Dairy (milk, cheese yogurt)
☐ Alcohol
☐ Coffee

Are you currently on a special diet? Y ○ N ○

☐ Autoimmune paleo (AIP)
☐ Paleo
☐ SCD
☐ GAPS
☐ Blood type
☐ Dairy restricted or dairy free
☐ Raw
☐ Vegetarian
☐ Vegan
☐ Gluten-free
☐ Other (please describe below)

If you checked "Other" from the question above, please describe in more detail here.

What percentage of your meals are home-cooked? Please describe.

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

Digestive health

Bowel Movement Frequency

☐ 1-3 times per day
☐ More than 3 times per day
☐ Not regularly every day

Bowel Movement Consistency

☐ Soft & well formed
☐ Often float
☐ Difficult to pass
☐ Diarrhea
☐ Thin, long or narrow
☐ Small and hard
☐ Loose but not watery
☐ Alternating hard and loose

Bowel Movement Color

☐ Medium brown
☐ Very dark or black
☐ Greenish
☐ Blood is visible
☐ Variable
☐ Yellow, light brown
☐ Chalky colored
☐ Greasy, shiny

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

Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you, 2) What did you treat it with, and 3) If you feel like you fully recovered from it:

Medical Status

Gastrointestinal

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now

Irritable Bowel Syndrome				☐	☐
Crohn's				☐	☐
Ulcerative Colitis				☐	☐
Gastritis or Peptic Ulcer				☐	☐
GERD (reflux or heartburn)				☐	☐
Celiac Disease				☐	☐
SIBO				☐	☐
Gut infections				☐	☐
Dysbiosis				☐	☐
Leaky gut				☐	☐
Food allergies, intolerances or reactions				☐	☐
Gallstones				☐	☐
Known absorption or assimilation issues				☐	☐
Other				☐	☐

Cardiovascular

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Heart attack				☐	☐
Heart Disease				☐	☐
Stroke				☐	☐
Elevated cholesterol				☐	☐
Arrhythmia (irregular heartbeat)				☐	☐
Hypertension (high blood pressure)				☐	☐
Rheumatic Fever				☐	☐
Mitral Valve Prolapse				☐	☐
Other				☐	☐

Hormones/Metabolic

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Type 1 Diabetes				☐	☐
Type 2 Diabetes				☐	☐
Metabolic Syndrome				☐	☐
Pre-Diabetes				☐	☐
Insulin Resistance or				☐	☐
Hypothyroidism (low thyroid)				☐	☐
Hyperthyroidism (overactive thyroid)				☐	☐
Hashimoto's (autoimmune hypothyroid)				☐	☐
Grave's Disease (autoimmune hyperthyroid)				☐	☐
Endocrine problems				☐	☐
Polycystic Ovarian				☐	☐

Syndrome (PCOS)					
Weight gain				☐	☐
Weight loss				☐	☐
Frequent weight fluctuations				☐	☐
Eating disorder				☐	☐
Hair loss				☐	☐
Infertility				☐	☐
Menopause difficulties				☐	☐
Other				☐	☐

Cancer

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Lung Cancer				☐	☐
Colon Cancer				☐	☐
Prostate Cancer				☐	☐
Breast Cancer				☐	☐
Ovarian Cancer				☐	☐
Skin Cancer (Melanoma)				☐	☐
Skin Cancer (Squamous, Basal)				☐	☐
Other				☐	☐

Genital & Urinary Systems

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Kidney Stones				☐	☐
Erectile Dysfunction or Sexual Dysfunction				☐	☐
Interstitial Cystitis				☐	☐
Gout				☐	☐
Frequent urinary tract infections				☐	☐
Frequent Yeast infections				☐	☐
Other				☐	☐

Musculoskeletal/Pain

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Osteoarthritis				☐	☐
Chronic Pain				☐	☐
Fibromyalgia				☐	☐
Sore muscles or joints, undiagnosed				☐	☐
Other				☐	☐

Immune/Inflammatory

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now

Chronic Fatigue Syndrome				☐	☐
Rheumatoid Arthritis				☐	☐
Lupus SLE				☐	☐
Raynaud's				☐	☐
Psoriasis				☐	☐
Mixed Connetive Tissue Disease (MCTD)				☐	☐
Poor immune function (frequent infections)				☐	☐
Food allergies				☐	☐
Environmental allergies				☐	☐
Multiple chemical sensitivities				☐	☐
Latex allergy				☐	☐
Hepatitis				☐	☐
Lyme (and coinfections)				☐	☐
Chronic Infections				☐	☐
(Epstein-Barr, Cytomegalo-virus, Herpes, etc.)				☐	☐
Other				☐	☐

Respiratory Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Asthma				☐	☐
Chronic Sinusitis				☐	☐
Bronchitis				☐	☐
Emphysema				☐	☐
Pneumonia				☐	☐
Sleep Apnea				☐	☐
Frequent or recurrent				☐	☐
Colds/Flus				☐	☐
Other				☐	☐

Skin Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Eczema				☐	☐
Psoriasis				☐	☐
Dermatitis				☐	☐
Hives				☐	☐
Rash, undiagnosed				☐	☐
Acne				☐	☐
Skin Cancer (Melanoma)				☐	☐
Skin Cancer (Squamous, Basal)				☐	☐
Other				☐	☐

Neurologic/Mood

Please list any of the following conditions that apply to your history and briefly describe your

symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Depression				☐	☐
Anxiety				☐	☐
Bipolar Disorder				☐	☐
Schizophrenia				☐	☐
Headaches				☐	☐
Migraines				☐	☐
ADD/ADHA				☐	☐
Autism				☐	☐
Mild Cognitive Impairment				☐	☐
Memory Problems				☐	☐
Multiple Sclerosis				☐	☐
ALS				☐	☐
Seizures				☐	☐
Alzheimer's				☐	☐
Other				☐	☐

Miscellaneous

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Treatment(s)	Dates	Past	Now
Anemia				☐	☐
Chicken Pox				☐	☐
German Measles				☐	☐
Measles				☐	☐
Mumps				☐	☐
Sleep Apnea				☐	☐
Whooping Cough				☐	☐
Tuberculosis				☐	☐
Known genetic variants (SNPs, polymorphisms, etc.)				☐	☐
Other				☐	☐

Please check frequency of the following:

	Yes	No	Sometimes
Short term memory impairment	☐	☐	☐
Shortened focus of attention and ability to concentrate	☐	☐	☐
Coordination and balance problems	☐	☐	☐
Problems with lack of inhibition	☐	☐	☐
Poor organization abilities	☐	☐	☐
Problems with time management (late or forget appts)	☐	☐	☐
Mood instability	☐	☐	☐
Difficulty understanding speech and word finding	☐	☐	☐
Brain fog, brain fatigue	☐	☐	☐
Lower effectiveness at work, home or school	☐	☐	☐

Judgment problems like leaving the stove on, etc	☐	☐	☐

Health Hazards

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?

Oral Health History

In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

Do you have any concerns about your oral or dental health? Such as having bleeding gums, the presence or removal of mercury amalgams, etc?

Lifestyle History

Have you had periods of eating junk food, binge eating or dieting?

List any known diet that you have been on for a significant amount of time

Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

Do you have any other unhealthy habits (physical, mental, or emotional)?

Sleep History

On average, how many hours do you sleep?

What time do you go to sleep at night?

Do you fall asleep in less than 30 minutes?

Are you satisfied with your sleep? Do you feel rested when you wake and that you have plenty of energy during the day?

For Women Only

How old were you when you first got your period?

How are/were your menses? Do/did you have PMS? Painful periods? If so, explain

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

Have you experienced any yeast infections or urinary tract infections? Are they regular?

Have you/do you still take birth control pills: If so, please list length of time and type

Have you had any problems with conception or pregnancy?

Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Sexual History

Do you have any concerns or issues with your sexual functioning that you'd like to share with us(pain with intercourse, dryness, libido issues, erectile dysfunction)?

Psychosocial History

Briefly outline a typical weekday. What do you do from waking to sleeping?

Time	Activity	Time	Activity

Please rate 1-10, how important these things are in your life

Career	Choose an item
Fun & Recreation	Choose an item
Money	Choose an item
Family & Friends	Choose an item
Health	Choose an item
Physical Environment	Choose an item
Romance	Choose an item
Personal Growth	Choose an item

How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

Stress

List the two most significantly stressful events in your life, from recent to most distant. Include the date of occurrence and whether it still impacts you.

On a scale of 1-10, one being low and 10 being high, what is the level of stress you are currently experiencing in your life?

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

(1 = low, 10 = high)

How do you handle stress?

Motivation and Health Goals

What do you hope to achieve with your consultation?

Though it may seem odd, please consider why you might want to achieve that for yourself

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

When is the last time you felt well?

Did something trigger your change in health?

What do you think is happening and why?

What do you feel needs to happen for you to get better?

How motivated are you on a scale of 1 (unmotivated) to 5 (very motivated) to make changes to your diet, take supplements, exercise, and make lifestyle changes? Answer each individually.