Sheryl Seliger, LCSW
Intuitive Health Practitioner
1446 South 900 East
Salt Lake City, UT 84105
ph. 801-556-8760 fax 801-410-4167

Intake Questionnaire for Chronic Health Issues

Client Name:
Date:
Birthday:
Height:
Weight:

Note to Clients: If filling out this form seems too overwhelming, you may request to schedule an appointment with our staff for a verbal telephone intake.
Note to Staff and Associates: Please make sure that Sheryl receives the completed Intake Questionnaire, and that an Assessment has been scheduled.

How did you hear about our healing community?

Health history - List the following and include dates:
Accidents

Injuries

Surgeries

Hospitalizations

Childhood serious illnesses

Adult serious illnesses

Blood transfusions

Significant scarring, c-section, lumbar puncture, etc.

Metal in your body from joint replacements etc

Head injury, spinal injury, or traumatic brain injury

Symptoms:
List your current symptoms, and how long you have had them.

On a scale of 1-10 where is your pain level most of the day?
Is your pain better or worse any time of day?

What type of pain do you experience and where is your pain?

What have you tried for pain management? Has anything worked?

Do you experience brain fog or mental confusion?

Do you have cold hands or feet?

Have you had any vision changes recently?

Have you had any hearing loss recently?

Have you had any hair loss recently?

Medical diagnosis, symptoms, medications, treatments

List your current health practitioners

What was happening in your life when the problems began?
(Move to a different house, auto accident, death in the family, etc.)

What kinds of treatments have your received?

What treatments helped and what didn't work?

Who else in your family has these symptoms?

List your current prescription medications.

List antibiotics and other medications you have taken in the past.

List your current supplements.

Medical Testing:

What medical testing have you had done related to your current symptoms and what were the test results?

What type of testing have you done for Lyme and Co infections and what were the results?

Have you done genetic testing (23 and me)?
Have you worked with someone to interpret the results?

Environmental Concerns:

Have you had testing for heavy metals? What were the results?

Have you had mercury removed from your mouth? If so, explain.

How many silver fillings, root canals/crowns? What kind of metal?

Do you experience any dental or jaw pain?
Do you grind your teeth at night or been diagnosed with TMJ?

Do you have pets?

List any known allergies or sensitivities to environmental substances.

Have you been exposed to mold that you were aware of? When, how long?

How many hours a day do you use a computer?

How many hours a day do you use a cell phone? How or where do you carry it?

Lifestyle:
Are you able to exercise? If so, how often and what kind?

What do you do to recreate/have fun? How often?

Do you have a spiritual or meditation practice?

Do you work? If so, how many hours a day and what kind of work?

Describe your typical work/play day:

What time of day do you feel best? worse?

Food:
Do you consider your appetite to be normal?

When and how often do you eat?

What foods do you eat most?

Do you usually eat sitting down or standing up?

Do you often get heartburn?

Do you have any known food allergies or sensitivities?

List any foods you don't eat? (wheat, dairy, eggs, meat, etc)

Elimination:
How often do you urinate?
How often do you move your bowels?
Do you tend towards constipation or diarrhea?
Do you see undigested food in stool frequently?
Do you get up in the middle of the night to urinate? How often?
Do you have a history of urinary tract infections?

Sleep:
What time do you typically go to bed?
What time do you typically get up?
Do you have trouble falling asleep and/or staying asleep?
Have you ever been diagnosed with sleep apnea?

Females:
Are you having monthly cycles?
Are your periods consistent each month?
Do you have pain and/or heavy bleeding?
Are your symptoms worse any time of the month?
Do you have a history of ovarian cysts, abnormal paps, polycystic ovary syndrome, endometriosis?

Social and Emotional Support:
What kind of social and emotional support do you have for your illness and health?

What kind of social and emotional stressors do you live with?
(ex: narcissistic or abusive spouse or parent, physically or mentally disabled child)

What kind of social support do you think you need for yourself and your family?
Individual counseling, family counseling, support group for spouse, resources for parents or family members to understand illness?

What are your financial resources? Spectrum of: funds readily available for any kind of treatment, to homeless or living on credit cards or extended family support. We need to know how to best support you in use of your funds with professional support and medical testing vs. do-it-yourself.

What kind of learner are you? Reader, listener, hands-on? Prefer to be given instructions and to do exactly as I am told vs. prefer to be given a range of ideas and figure it out for myself. Prefer visual charts, phone calls, Skype sessions, home visits, etc.

What else would you like us to know about your story?