



Client Intake Form

Please complete this form and email it to hello@thewellnessrevolution.health

Section 1: Personal Information

Full Name: _____

Date of Birth: ____ / ____ / ____

Gender: Male Female

Phone Number: _____

Email Address: _____

Address: _____

Emergency Contact Name & Phone: _____

Section 2: Health Goals

What are your top 3 health goals?

1. _____

2. _____

3. _____

What are your biggest health concerns or symptoms?

Section 3: Medical History

Primary Care Physician: _____

Current Diagnoses: _____

Past Surgeries or Hospitalizations: _____

Allergies (food, medication, environmental): _____

Current Medications & Supplements:

| Name | Dosage | Frequency | Reason |

Name	Dosage	Frequency	Reason

Section 4: Lifestyle & Nutrition

Typical Daily Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water Intake (oz/day): _____

Caffeine Intake (type & amount): _____

Alcohol Use: Never Occasionally Frequently

Tobacco Use: Never Occasionally Frequently

Exercise Routine (type, frequency): _____

Section 5: Stress & Sleep

Stress Level (1–10): _____

Main Sources of Stress: _____

Sleep Quality: Poor Fair Good Excellent

Hours of Sleep per Night: _____

Do you wake up feeling rested? Yes No

Section 6: Family History

Please indicate if any family members have had the following:

Heart Disease ____

Diabetes ____

Cancer ____

Autoimmune Disorders ____

Mental Health Conditions ____

Section 7: Additional Information

Is there anything else you'd like your practitioner to know?

Are you able to:

Swallow Capsule Vitamins: _____

Self-Administer Injections (or have someone to do it for you?): _____

Do you have a preference? _____

When is the last time, if ever, you've had labs run to identify and deficiencies? If you have within the last 3 months, are you able to share your report/findings? _____