BetterLiving
Wellness Clinic and Health Store

Clinic Intake Form

Name:_____ Email:_____

Address: _____ _____

Home #: _____ Cell #:_____

Preferred method of contact for follow-up:_____

Age: _____ Weight: _____ Height: _____ Referred by: _____

Occupation: _____ Blood Type: _____

What brings you here?_____

_____

Short-term health goals: _____

Long-term health goals: _____

What vitamins do you currently take, and dosages? _____

_____

Allergies?_____

Surgeries? _____

# of cups per day: coffee ____ tea ____ water ____ pop ____ alcohol ___ milk ___ juice ____

Medication	Reason of taking?	How long?

This information is provided for a nutritional assessment. I understand that the information I am seeking is of a nutritional nature and **not** a medical diagnosis.

Signature (Legal Guardian): _____ Name (Print)_____

Date: _____

Better Living 1500 Royal York Rd
416-249-1895 www.betterliving.co