CUTLER INTEGRATIVE MEDICINE

TRUE-RIFE INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person ***3 business days*** before your appointment.

PROFILE:

Name: _____ Gender: ☐ M ☐ F Age: _____

Today's Date: _____/_____/_____ (dd/mm/yyyy) Date of Birth: _____/_____/_____ (dd/mm/yyyy)

Address: _____

_____

Telephone: (Home) _____-_____-_____ (Cell) _____-_____-_____ (Work) _____-_____-_____

Prefer Email Correspondence? ☐ Y ☐ N Email: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Children / Ages: _____

_____

How did you hear about us? _____

Have you ever had True-Rife? ☐ Y ☐ N When? _____

Why have you chosen True-Rife? _____

May we give you appointment reminder calls? ☐ Y ☐ N (phone) _____-_____-_____

May we leave you phone messages? ☐ Y ☐ N (phone) _____-_____-_____ ☐ same as above

Name of Medical Doctor / Family Physician: _____ Telephone: _____-_____-_____

EMERGENCY CONTACT:

Name:	Relationship:
Telephone: (home) _____-_____-_____	(cell) _____-_____-_____ (work) _____-_____-_____

Please list all current medications (prescription or over-the-counter) and supplements (herbs, vitamins)

Name of Drug / Supplement	Used For	Date Started	Dose / Frequency

List past prescription medications:

List any known allergies (include drugs, food, environmental, chemical and etc.) and the reaction(s) from them.

_____

Y = current	N = never	P = past

Good energy? ☐ Y ☐ N ☐ P Rate your energy level: _____/10 (10 = best)

Fatigue: ☐ Y ☐ N ☐ P Rate your stress level: ☐ Low ☐ Average ☐ High ☐ Unbearable

How often do you exercise? _____ What type of exercise? _____

How many hours of sleep per night? _____ If waking up frequently, what is the reason? _____

How much water do you drink per day? _____

Type of water that you drink? _____

Please record your diet for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			

How often do you have a bowel movement? _____ Do you use laxatives? ☐ Y ☐ N

Do you tends towards? ☐ constipation ☐ diarrhea ☐ both ☐ other: _____

What is the color of your stool? _____ Any undigested food in stool? ☐ Y ☐ N

What is the shape of your stool? ☐ Well-formed ☐ Ribbon-like ☐ Pellets ☐ Other: _____

How many times have you been treated with antibiotics? For what condition(s)?_____

Have you ever used probiotics or yogurt after antibiotic use? ☐ Y ☐ N _____

Rate your stress level: ☐ Low ☐ Average ☐ High ☐ Unbearable

Outlets to relieve stress: _____

Describe your current emotional state? _____

What is your greatest health concern? _____

_____

How does it limit you the most? _____

How committed are you towards making valuable health changes? ☐ Little ☐ Moderate ☐ Very

Would you be interested visiting with Dr. Cutler in regards to your health concern(s)? ☐ Y ☐ N ☐ Maybe in the future

Is there any other information that you feel is important that has not been covered? _____

_____