LENS 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 LENS Therapy? ☐ Y ☐ N When? ___________________________________

Why have you chosen LENS Therapy? ____

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? ______________________________

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