

# New Client Intake Form - Part 1

## INSTRUCTIONS:

Please be assured that all your responses will be kept confidential. If you are feeling rushed or preoccupied, we kindly ask you not to proceed with this questionnaire. Your input is vital for your overall health evaluation. If you are unsure about a question or find it unclear, please mark it with a question mark (?). Thank you.

Please check the statement that best represents your purpose in seeking alternative health care:

- I believe that I am a generally healthy individual seeking guidance to further improve and maintain my well-being. My goal is to enhance my overall health so that I can extend my lifespan and enjoy a higher quality of life.
- I have noticed certain health issues that are hindering my ability to fully embrace life. I am keen on addressing these concerns to not only increase my longevity but also optimize my well-being.
- I am experiencing serious health issues that seem to be unmanageable or unresponsive to conventional healthcare methods. My aim is to address these issues and improve my longevity while also elevating my quality of life.

Top 3 Health Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Top 3 Health Concerns/Complaints/Illnesses:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**FAMILY MEDICAL HISTORY** (check off any family heredity issues):

- Diabetes  
  High or Low Blood Pressure  
  Heart Trouble  
  TB  
  Allergies  
  Asthma  
  Epilepsy  
 Sinus Problems  
  Ulcers  
  Eye Disease  
  Arthritis  
  Rheumatism  
  Alcoholism  
  Drug Addiction  
 Kidney Disease  
  Liver Problems  
  Spinal Problems  
  Mental Disorders  
  Other: \_\_\_\_\_  
 Cancer | Describe: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:**

- Are you taking any medication? Yes  No  What type and how often? \_\_\_\_\_
- Have you ever had any surgery? Yes  No  When and what type? \_\_\_\_\_
- Have you ever been in any accidents? Yes  No  If yes, explain: \_\_\_\_\_
- Have you had any fractures, torn ligaments, etc.? Where? \_\_\_\_\_
- Have you ever been seriously ill? Yes  No  If yes, what type? When? \_\_\_\_\_
- Known food allergies/sensitivities: \_\_\_\_\_

**LIFESTYLE** (check off all that apply to you):

- HABITS:**  Cigarettes/Cigars | Daily #: \_\_\_\_  Recreational Drugs | What type & frequency: \_\_\_\_\_  
 Medicine/Pill/Drug Abuse | What type & frequency: \_\_\_\_\_  Other: \_\_\_\_\_
- TYPICAL DIET:**  Beef  Pork  Poultry  Eggs  Fish  Tofu  Beans  Cold cuts  Sausages  
 Hot Dogs  Cheese  Yogurt  Ice cream  Milk  Soy  Margarine  Butter  Bread  
 Pasta  Rice  Potatoes  Fried Foods  Cereal  Desserts  Chocolate  Candies  Chips  
 Fresh Fruits/Vegetables  Frozen Fruits/Vegetables  Canned Fruits/Vegetables  Dried Fruits/Vegetables  
 Tap Water  Filtered Water  Bottled Water  Salt  Sea Salt  Sugar  Raw Sugar  Honey/Agave  
 Sweeteners \_\_\_\_ # of packets daily  Other: \_\_\_\_\_  
 Cook with Microwave  Cook with Aluminum  Eat take out or in restaurants  Organic/Health Foods
- EXERCISE:**  Never  Little  Moderate  Heavy  Type of Exercise: \_\_\_\_\_
- MISC:**  Single  Married  Divorced  Common-law  Widowed  Children # \_\_\_\_ | Ages: \_\_\_\_\_  
 Stressful home conditions  Trouble sleeping  Trouble relaxing  Unhealthy home (mold, smokers, etc.)  
 Stressful job  Unhealthy work conditions (factory work, printing, chemicals, etc.)  Relationship problems

# New Client Intake Form - Part 2

**PLEASE PROVIDE RESPONSES TO THE QUESTIONS BELOW. THE MORE DETAILED YOUR ANSWERS, THE GREATER OUR COMPREHENSION OF YOUR CONCERNS.**

1. How much water do you drink daily?  Less than 4 glasses •  4-6 glasses •  6-8 glasses •  More than 8 glasses  
What type?  Tap Water •  Bottled Water | Brand/Type (distilled, reverse osmosis, other): \_\_\_\_\_
2. How many cups of coffee, tea or stimulant drinks do you consume daily?  
 Coffee •  Tea •  Pop/Power Drinks |  None •  1-2 •  3-4 •  5 or more
3. What type and how many alcoholic drinks do you enjoy weekly?  
 Beer •  Wine •  Liquor |  None •  1-2 •  3-4 •  5-10 •  More than 10 •  More than 20
4. What blood type are you?  A •  B- •  B+ •  AB- •  AB+ •  O- •  O+ •  Don't recall/Not sure
5. What is your typical breakfast? \_\_\_\_\_
6. What is your typical lunch? \_\_\_\_\_
7. What is your typical dinner? \_\_\_\_\_
8. List typical snacks and desserts: \_\_\_\_\_
9. What time do you eat in the evening?  Before 6pm •  Between 6-8 •  After 8 | Do you skip meals:  Yes  No
10. How often do you consume nuts, seeds and oily fish?  Daily •  1-3 Week •  Seldom
11. What type of protein do you eat in a typical day? •  Fish •  Chicken •  Meat •  Beans •  Tofu  
 Eggs •  Nuts •  Ancient Grains •  Protein Shakes •  Other: \_\_\_\_\_
12. How often do you eat wheat (bread, pasta, cakes, etc)?  None •  1-2 portions daily •  3-4 daily  5 or more
13. How many servings of fruit do you eat a day?  None •  1-2 •  3-4  5+ •  Raw •  Canned •  Frozen  
What type? \_\_\_\_\_ Method:  Raw •  Cooked •  Microwaved
14. How many servings of veggies do you eat a day?  None •  1-2 •  3-4  5+ •  Raw •  Canned •  Frozen  
What type? \_\_\_\_\_ Method:  Raw •  Cooked •  Microwaved
15. What supplements do you take and why? \_\_\_\_\_  
Quality/Brand:  Grocery/Drug Store •  Health Store •  Professional Brand/Practitioner Recommended
16. Describe any digestive problems? \_\_\_\_\_  
Frequency of Bowel Movement: \_\_\_ x Daily or \_\_\_ x Weekly •  Constipation •  Diarrhea  
Frequency of Urination:  1-2 Daily •  Normal •  Too often/Almost as fast I drink, I release
17. Sleep patterns:  Less than 6 hours •  6-8 hrs •  8-10 hrs  More than 10 hrs •  Restful •  Restless  
During the day do you get tired?  Never •  Rarely •  Sometimes •  Usually | At what time(s): \_\_\_\_\_
18. How many hours are you sitting daily:  Less than 6 hours •  6-10 hrs •  10-14 hrs •  More than 14 hrs
19. Hours combined on computer, cell/phone and watching TV:  Less than 6 hours •  6-10 hrs •  More than 10 hrs
20. Have you ever had the flu shot?  No •  Yes | If yes, frequency & approx. date of last shot: \_\_\_\_\_  
Vaccinations:  Measles •  Mumps •  Chicken Pox •  Polio •  Tetanus •  Hepatitis C  
Viruses:  Measles  Mumps  Chicken Pox  Mono •  Cold Sores •  Herpes •  Acne •  Other: \_\_\_\_\_
21. Deodorant:  Antiperspirant •  Regular Deodorant •  Natural Product •  None
22. Is there anything else that you can think of that may contribute to your current health condition?  
\_\_\_\_\_
23. How do you relieve your stress: \_\_\_\_\_ | Do you have any hobbies: \_\_\_\_\_
24. What type of practitioners do you visit monthly or regularly?  Family Doctor •  Specialist in: \_\_\_\_\_  
 Naturopath •  Chiropractor •  Acupuncturist •  Massage •  Reiki/Energyworker •  Other: \_\_\_\_\_

# New Client Intake Form - Part 3

## INSTRUCTIONS:

Please indicate any health conditions you have encountered in the past few months or have experienced recurring symptoms throughout your life. For conditions with multiple symptoms listed (indicated with a colon ":" or separated by a dividing line "|"), please select the options that best match your experience.

### HEAD | NEUROLOGICAL

- ADD/ADHD
- Addiction
- Anxiety
- Autism
- Autonomic Nervous System Imbalances
- Bipolar
- Cloudy or Foggy Thinking
- Coordination Problems
- Concentration Difficulties
- Confusion
- Depression
- Dyslexia
- Equilibrium Imbalances
- Excessive Daydreaming
- Excessive Drowsiness
- Fainting
- Fears, Paranoia
- Feeling of Fullness in Head
- Hair Loss
- Headaches
- Learning Difficulties/Disabilities
- Light-headedness
- Manic depression
- Memory Loss: Long Term | Short Term
- Mental Dullness/Tiredness
- Mental Illnesses
- Migraines
- Mood Swings
- Nervousness
- Nightmares | Night Terrors
- Panic Attacks
- Pituitary Problems
- Schizophrenia
- Seizures
- Sinus Congestion
- Sleep: Apnea | Disorders | Problems
  - Hypersomnia | Hyponia | Insomnia
  - Narcolepsy | Sleep Talking/Walking
- Sleepiness After Eating
- Suicidal Tendencies
- Tinnitus
- Tourette Syndrome
- Other: \_\_\_\_\_

### EYES | VISION

- Blindness | Loss of Vision
- Bloodshot Eyes
- Blurred Vision
- Cataracts
- Conjunctivitis (Pink Eye)

- Darkness Under Eyes
- Eye Irritations: Itchy | Watery | Inflamed
- Eye Pain
- Glaucoma
- Macular Degeneration
- Poor Night Vision
- Puffy Eyes
- Sensitivity to Light
- Tired Eyes
- Vision: Farsightedness | Nearsightedness
- Wears Sunglasses Daily
- Other: \_\_\_\_\_

### EARS

- Dizziness
- Ear Drainage
- Earaches/Pain
- Fluid in Middle Ear
- Hearing Loss
- Itching Ear
- Loss of Balance
- Over Sensitivity to Sounds
- Recurrent Ear Infections
- Ringing in Ears
- Other: \_\_\_\_\_

### NOSE

- Excessive Mucous Formation
- Loss of Smell
- Nose Bleeds
- Nose Pain
- Over Sensitivity to Smells
- Recurrent Sinusitis/Sinus Problems
- Runny nose
- Stuffy nose
- Other: \_\_\_\_\_

### MOUTH | DENTAL

- Amalgam (Mercury in Fillings)
- Bleeding Gums
- Blisters
- Bruxism
- Canker/Cold Sores
- Dry Mouth | Lips
- Enamel Disorders
- Excessive Cavities
- Gingivitis | Periodontitis
- Grind Teeth
- Gum Disease
- Itchiness on Roof of Mouth
- Loss of Taste

- Odour in Mouth Upon Waking
- Over Sensitivities to Taste
- Pain in Gums | Mouth
- Root Canal
- Soft/Porous Teeth
- Toothaches
- TMJ | Tightness in jaw
- Other: \_\_\_\_\_

### THROAT

- Chronic Cough
- Difficulty Swallowing
- Dryness in Throat
- Gagging
- Goitres
- Hoarse or Sore Throat
- Laryngitis
- Lump in Throat
- Slurred Speech
- Stuttering
- Swollen Glands
- Thyroid Imbalances
- Tonsillitis
- Other: \_\_\_\_\_

### NECK

- Lack of Mobility in Neck Region
- Neck pain
- Stiff neck
- Whiplash
- Other: \_\_\_\_\_

### ENDOCRINOLOGY

- Thyroid: Hyper | Hypo
- Graves' Disease
- Hashimoto's Disease
- Goiter
- Poor: Hair | Nail Growth
- Other: \_\_\_\_\_

### MISCELLANEOUS BLUE IMBALANCES

- Atlas Problems | Poor Posture
- Fever
- Hyperactivity
- Inability to: Lose | Gain Weight
- Melancholy
- Other: \_\_\_\_\_

### IMMUNOLOGY

- Auto-Immune Disease
- Cancer (what type): \_\_\_\_\_

# New Client Intake Form - Part 4

- Chronic Fatigue
- Ear Infections
- Environmental Allergies
- Food Allergies
- Frequent Colds or Flus
- Inflammation
- Lymph Problems
- Sluggish Lymph System
- Strong Body Odour
- Upper Respiratory Allergies
- Use of Antibiotics
- Yeast Infections
- Other: \_\_\_\_\_

## ARMS, HANDS & SHOULDERS

- Hands: Clammy | Cold | Dry | Sweaty
- Elbow pain
- Numbness/Stiffness/Soreness in Fingers
- Prickling Sensation in Hands
- Shoulder Pain
- Swollen Fingers
- Upper Arm Pain
- Wrist Pain
- Other: \_\_\_\_\_

## RESPIRATORY

- Airborne Allergies
- Asthma
- Bronchitis
- Chronic Cough
- Chronic Infections
- Chronic Mucus/Phlegm
- Coughing Blood
- Difficulties Breathing When Lying Down
- Emphysema
- Mold
- Pain When Breathing
- Pneumonia
- Pulmonary Vascular Disease
- Shortness of Breath
- Sinus Infections / Polyps
- Tightness in Chest
- Other: \_\_\_\_\_

## CARDIOVACULAR | BREAST

- Blood Pressure - High
- Blood Pressure - Low
- Breast Tenderness
- Chest Congestion
- Chest Pain
- Cholesterol Level - High LDL
- Cholesterol Level - High Total
- Cholesterol Level - Low LDL
- High Triglycerides
- Cysts in Breast or Lymph Glands
- Fainting
- Heartbeat Irregularity
- Heart Attack
- Heart Disease

- Heart Pain
- Heart Palpitations
- Heart Rate 85-100 beats per min.
- Tachycardia - 100+ beats per min.
- Phlebitis
- Stroke
- Varicose Veins
- Other: \_\_\_\_\_

## MISCELLANEOUS GREEN IMBALANCES

- Hypertension
- Joint Aches and Pains
- Muscle Aches and Pains
- Muscle Weakness
- Passivity/Lethargy
- Other: \_\_\_\_\_

## LIVER | HEPATIC

- Anemia
- Chemical Sensitivities
- Fatty Liver
- Gallstones
- Hepatitis: A | B | C (circle one)
- Liver problems
- Other: \_\_\_\_\_

## METABOLIC

- Diabetes: Type I | Type II
- Hypoglycemia
- Difficulty Gaining Weight
- Difficulty Losing Weight
- Overweight
- Metabolic Syndrome
- Other: \_\_\_\_\_

## GASTROINTESTINAL | STOMACH

- Abdomen Pain or Cramps
- Acid Reflex/Heartburn
- Bad Breath
- Bloating/Bloated Stomach
- Difficulty Swallowing
- Candida
- Colon Polyps
- Constipation
- Crohn's Disease
- Diarrhea
- Diverticulosis/Diverticulitis
- Excessive belching
- Flatulence (passing gas)
- Food Cravings
- Food Intolerances | Allergies
- Hemorrhoids
- Hernia: Inguinal | Hiatus
- Indigestion
- Irritable Bowel Syndrome (IBS)
- Mucus
- Nausea
- Parasites
- Poor Appetite

- Rectal Pain
- Stomach Fullness Long After Eating
- Stools: Runny | Hard | Normal | Blood  
Yellow | Red | Black
- Ulcerative Colitis
- Ulcers
- Vomiting
- Other: \_\_\_\_\_

## MISCELLANEOUS YELLOW IMBALANCES

- Colitis
- Herpes
- High Toxin Levels
- Nervousness
- Parasites
- Poor Work Habits
- Ringworm
- Salt Cravings: Salt | Sweet
- Other: \_\_\_\_\_

## URINARY | RENAL

- Bladder: Infections | Cystitis
- Blood in Urine
- Difficulties Urinating
- Discolouration in Urine
- Frequent Urination
- Inability to Hold Urine
- Infrequent Urination
- Gout
- Kidney Stones
- Painful Urination
- Strong Odour in Urine
- Swelling of the Hands, Feet or Ankles
- Water retention

## SKIN | DERMATOLOGY

- Acne
- Bruise Easily | Tender areas
- Change in Skin Texture
- Dandruff
- Eczema | Dermatitis
- Excessive: Dry | Oily Skin
- Hives
- Itchy Skin
- Liver Spots
- New Moles
- Pallor
- Pimples: Lower (chin) | Mid (nose/cheeks)  
Upper Face (forehead) | Neck | Head
- Poor Healing of Cuts/Sores/Wounds
- Psoriasis
- Rashes
- Rosacea
- Sensitive to Touch
- Sores
- Thinning: Skin | Skin Tags
- Varicose Veins
- Other: \_\_\_\_\_

# New Client Intake Form - Part 5

## REPRODUCTIVE ORGANS

### WOMEN ONLY:

- Bloating
- Frequent Yeast Infections
- Frigidity
- Hot Flashes/Night Sweats
- Hysterectomy
- Menopause
- Menstrual Cramps/Pain
- Nursing
- Painful Intercourse
- Periods: None | Irregular | Painful | Heavy  
     Blood Clots
- Perimenopause
- Polycystic Ovaries
- PMS/Mood Swings
- Pregnant
- Problems Conceiving
- Vaginal Yeast Infections
- Vaginal Itching
- Vaginal Discharge
- Other: \_\_\_\_\_

### FOR BOTH SEXES:

- Bladder Issues
- Burning Urination
- Frequent Urination
- Loss of Libido
- Urinary Tract Infections
- Other: \_\_\_\_\_

### MEN ONLY:

- Erectile/Impotency Dysfunction
- Infertility
- Prostate Enlargement
- Urinary Difficulties: Slow | Dribbling
- Vasectomy
- Other: \_\_\_\_\_

## SEXUAL HEALTH

- Herpes Simplex II (Genital)
- HIV
- STD's
- Other: \_\_\_\_\_

## MISCELLANEOUS ORANGE IMBALANCES

- Alcohol Abuse
- Allergies
- Bacterial problems
- Dizziness
- Drug Abuse
- Eating disorders (Binge or Spree Eating)
- Emotional Instability
- Excessive Hunger
- Hard Stools
- Hypersensitive to Environment
- Muscle Cramps | Spasms
- Night Sweats
- Other: \_\_\_\_\_

## MUSCLE, BONE & JOINT

- Arthritis: Osteo | Rheumatoid
- Chronic Pain: Muscles | Joints
- Osteoporosis or Osteopaenia
- Other: \_\_\_\_\_

## BACK

- Pain between shoulder blades
- Lower back pain
- Muscle spasms in back
- Spinal meningitis
- Other: \_\_\_\_\_

## LEGS & FEET

- Ankle | Knee Problems
- Cold Feet
- Numbness in Legs | Feet

- Pain in Buttocks
- Pain in Feet
- Pain in Hip Joints
- Restless Leg Syndrome
- Swollen Ankles or Feet
- Varicose Veins
- Circulation Problems

## MISCELLANEOUS RED IMBALANCES

- Aggressive Behaviour
- Anemia
- Bladder Infections
- Brittle Bones
- Chronic Fatigue
- Constipation
- Depression
- Difficulties Waking Up
- Feeling Rundown
- Frequent Colds
- Heaviness: Mentally | Physically
- Hemorrhoids/Piles
- Hyperactivity
- Irritability
- Lack of Sex Drive
- Obesity
- Restlessness
- Rheumatism | Arthritis
- Sciatica
- Tired For No Reason
- Other: \_\_\_\_\_

## CONDITIONS

- Aids
- Blood Disorders
- Hemophilia
- Other Contagious Disease
- Multiple Sclerosis
- Other: \_\_\_\_\_

Circle appropriate number: 1 = Poor | 2 = Below Average | 3 = Average | 4 = Very Good | 5 = Excellent

Overall state of Health & Well Being: 1 - 2 - 3 - 4 - 5

Daily Energy Level: 1 - 2 - 3 - 4 - 5

Support of Family & Friends: 1 - 2 - 3 - 4 - 5

Support of Employer & Coworkers: 1 - 2 - 3 - 4 - 5

Handling of Stress: 1 - 2 - 3 - 4 - 5

Overall Enjoyment of Life: 1 - 2 - 3 - 4 - 5

I understand that a ChromaLight Practitioner does not have the authority to prescribe, treat, or diagnose any specific medical condition. I, the undersigned, am freely choosing to undergo a Light Therapy Treatment. Any discussions regarding general health conditions are considered my own personal opinion, and I acknowledge the importance of following my doctor's advice as recommended by the ChromaLight Therapist.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Height: \_\_\_\_\_  
Month Date Year

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_ Weight: \_\_\_\_\_