Boudreaux's NEW DRUG STORE
The Problem Solvers
404 East Prien Lake Road - Lake Charles, LA
Phone: 337-436-7216 - Fax: 337-436-7217 - TF: 800-897-7724

Client Intake Form

Name: (first)_____(last)_____

Address:_____ **City**_____ **State:**_____ **Zip:**_____

Date of Birth _____

Phone: (cell)_____ (home)_____ **Occupation:**_____ **Hrs worked/week**_____

Health Concerns/Complaints_____
_____
_____

Have you ever been diagnosed with problems with any of the following? Check Yes or No

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Digestive	☐	☐	Ulcers	☐	☐	Hiatal Hernia	☐	☐	Burping/gas heartburn	☐	☐
Lungs	☐	☐	Asthma	☐	☐	Allergies	☐	☐	Fainting	☐	☐
Heart	☐	☐	H/L Blood Pressure	☐	☐	Circulation	☐	☐	Edema	☐	☐
Ovaries	☐	☐	Bleeding	☐	☐	PMS	☐	☐	Menopause	☐	☐
Breast	☐	☐	Headaches	☐	☐	Fatigue	☐	☐	Adrenals	☐	☐
Thyroid	☐	☐	Weight	☐	☐	Throat	☐	☐	Numbness in Hands/feet	☐	☐
Spleen	☐	☐	Pancreas	☐	☐	Diabetes	☐	☐	Hypoglycemia	☐	☐
Gallbladder	☐	☐	Liver	☐	☐	Skin/acne	☐	☐	Anemia	☐	☐
Kidneys	☐	☐	Fibromyalgia	☐	☐	Prostrate	☐	☐	Cancer	☐	☐
Insomnia	☐	☐	Anxiety	☐	☐	Depression	☐	☐	Other	☐	☐

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FOOD JOURNAL QUESTIONS

Describe your daily meals for 3 days. Be specific as possible. For example, was your food fried, grilled, baked? Is any dairy low-fat or regular? Include beverages, (coffee, tea, soda alcohol, other) any snacks and how much you consumed. (serving sizes).
Breakfast:
Day 2
Day 3
Lunch:
Day 2
Day 3
Dinner:
Day 2
Day 3
Snacks:
Day 2
Day 3
Beverages:
Day 2
Day 3
Cravings: state what for and time of day:
Day 2
Day 3
Snacks:
Day 2
Day 3

Consultant Questions:

1. Do you drink coffee on an empty stomach? **Yes** ☐ **No** ☐

2. Do you eat breakfast on a regular basis? **Yes** ☐ **No** ☐

3. Do you often eat out or at home?

4. How many fast food items do you eat per day?

5. How many refined sugar items do you eat per day? (Candy, pastries, dessert)

6. How many servings of bread, pasta and other processed carbohydrates do you eat per day?

7. Do you eat organic fruits and/or vegetables every day?

8. How many servings of dairy do you eat per day?

9. How many servings of processed or smoked meats (hot dogs, sausage, bologna etc) per day?

10. What is your occupation?

11. Are you active or sedentary at your job?

12. How many hours do you work per week on average?

13. Do you or anyone in your home smoke?

14. Do you currently have or ever had a Candida albicans health issue?

Surgeries:

List all major surgeries you have ever had along with the reason:

Year	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

List all allergies to medications and the reaction you had to the medicine:

Medicine	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications:

List ***ALL*** medications and supplements you are currently taking (including prescribed, over-the-counter, herbs, vitamins, etc; write on the back of this sheet or a separate page if necessary.)

Medication Name	Strength	Date Started	Times Per Day
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9.)			

List medications previously taken:

Medication Name &Dose	Date Started	Date Stopped	Reason for Stopping
_____			
_____			
_____			

Are you currently pregnant or nursing?

Mark any potentially harmful elements you regularly come in contact with at home or at your workplace:

Humidity	Mildew	Poor ventilation	Air conditioning
Carpet 4 yrs+	Smog	Fluorescent lighting	Strong cleaners
Insect repellants	Lawn chemicals	Garden chemicals	High traffic area

Goals :

Please use the space below to describe your goals, or what you hope to achieve with this consultation visit. (Please be as specific as you can)