GLUTENfreeRN™
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Health Intake Form

Name_____ Date _____

Address_____City/State/Zip_____

Phone #
(Home)_____(Cell)_____

Email_____ Age_____

Date of Birth_____ Gender: Female_____ Male_____

Primary Care Physician:

Name:_____ Phone:_____

How did you hear about our center? _____

_____

What are your most important health concerns? List in order of importance:

1)_____

2)_____

3)_____

4)_____

If you have already been diagnosed with celiac disease/gluten intolerance please state when and how you were diagnosed.

_____

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_____

Please list any autoimmune diseases that you have:

_____

_____

_____

_____

For the following, please circle Y=a condition you have now P=a condition you had in the past N=never had the condition

MENTAL/EMOTIONAL

ADD/ADHD Y P N
Emotional problems Y P N
Depression Y P N
Mood Swings Y P N
Anxiety or nervousness Y P N
Tension Y P N
Memory problems Y P N
Poor concentration Y P N
Seasonal depression Y P N

ENDOCRINE

Hypothyroid Y P N
Heat or cold intolerances Y P N
Hypoglycemia Y P N
Diabetes Y P N
Excessive thirst Y P N
Excessive hunger Y P N
Fatigue Y P N

CARDIOVASCULAR

Heart disease Y P N
Fainting Y P N
High/Low blood pressure Y P N
Palpitations/Fluttering Y P N
Blood clots Y P N
Chest pain Y P N

GASTROINTESTINAL

Trouble swallowing Y P N
Heartburn Y P N
Change in appetite Y P N
Ulcer Y P N
Nausea Y P N
Vomiting Y P N
Blood in stool Y P N
Pain or cramps Y P N
Constipation Y P N
Belching or passing gas Y P N
Diarrhea Y P N
Black stools Y P N
Gall Bladder disease Y P N
Jaundice (yellow skin) Y P N
Liver Disease Y P N

OTHER

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_____

_____

FAMILY HISTORY – Please list family medical history

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