CONFIDENTIAL CLIENT INTAKE FORM

INTAKE DATE: _____ RECOMMENDED START DATE: _____ AUTO REORDER? Y / N
HOME DELIVERY? Y / N ABLE TO PICK-UP? Y / N - SLO / CAMBRIA / TWK
PAYING CLIENT? Y / N PAY IT FORWARD? Y / N for FULL($50) / 50% / AMT: $_____
REFERRED TO US BY: _____ TWK STAFF TAKING INTAKE: _____

CLIENT CONTACT INFORMATION:

NAME: _____ DOB:_____ WEIGHT TODAY: _____ GOAL WEIGHT: _____
ADDRESS: _____ CITY:_____ PHONE: _____
EMAIL: _____ 2ND PHONE: _____
SECONDARY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

HEALTH / DIETARY INFORMATION:

ARE YOU WILLING TO ALLOW CHANGES THAT CAN IMPROVE YOUR OVERALL WELLNESS AND QUALITY OF LIFE? Y / N
OVERALL HEALTH: POOR / FAIR / GOOD / EXCELLENT DESCRIBE YOUR STRESS LEVEL: MILD / MODERATE / SEVERE
WHAT ARE YOUR PRIMARY HEALTH CONCERNS AND/OR DIAGNOSIS:
_____
_____

HEALTH CONDITIONS:	YES	NO	NOTES
Non-Food Allergies			
Blood Sugar / Diabetic			
Cancer			
Candida			
Cardiac			
Digestive			
Immune System			
Weight Control			
Other:			

DESCRIBE YOUR AVERAGE DAILY FOOD INTAKE, INCLUDING QUANTITY AND APPROX TIME OF DAY:
BREAKFAST @ _____ AM / PM _____ LIQUIDS: _____
LUNCH @ _____ AM / PM _____LIQUIDS: _____
DINNER @ _____ AM / PM _____ LIQUIDS: _____
SNACKS @ _____ AM / PM _____ LIQUIDS: _____
SNACKS @ _____ AM / PM _____ LIQUIDS: _____
FAVORITE FOODS INCLUDE: _____

FOOD SENSITIVITIES:	YES	NO	NOTES
Citrus			
Dairy / Lactose Intolerant			
Eggs			
Garlic / Onion			
Nuts / Peanuts / Seeds			
Poultry			
Seafood / Shellfish			
Sodium			
Soy foods			
Sugars			
Wheat / Glutens /Yeast			
Other:			

NAME: _____

DEMOGRAPHIC INFORMATION (used for grant writing purposes):

RACIAL/ETHNIC: ____CAUCASIAN ____HISPANIC ____AFRICAN AMERICAN
____ASIAN ____NATIVE AMERICAN ____OTHER

PLEASE CHECK ALL THAT APPLY: ____DISABLED ____UNINSURED ____UNDERINSURED
____UNEMPLOYED ____HOMELESS

HOUSEHOLD INCOME BRAKCET: ____ UNDER $10,000 ____ $10,000 - $25,000 ____ $25,000 - $45,000
____SSI $_____ ____ $45,000 - $60,000 ____ $60,000 - $75,000 ____ $75,000 - $95,000
____SSDI $_____ ____ $95,000 – OVER $100,000 ____UNSURE

FAMILY SIZE LIVING AT HOME: ____ SINGLE ____ COUPLE ____3-5 FAMILY MBRS ____5-7 FAMILY MBRS

NOTES:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CLIENT AGREEMENT

PLEASE REVIEW THE INFORMATION DETAILED ABOVE. IS EVERYTHING CORRECT? Y / N IF NO, PLEASE DESCRIBE:
_____
_____

_____ *(INITIAL) I AGREE TO DO MY PART IN MY OWN HEALING JOURNEY BY PRACTICING HEALTHY HABITS AND LETTING GO OF THOSE HABITS WHICH NO LONGER SUIT MY DESIRE FOR A HEALTHIER LIFE.*

_____ *(INITIAL) I UNDERSTAND THAT THE WELLNESS KITCHEN IS HERE FOR EDUCATIONAL AND COMPLIMENTARY HEALING PURPOSES ONLY AND WOULD NEVER ADVISE AGAINST THE RECOMMENDATIONS OF MY PRIMARY CARE PROVIDER.*

_____ *(INITIAL) IT REMAINS MY DECISION TO PARTICIPATE OR NOT IN ANY CLASSES OR PROGRAMS AVAILABLE AT THE WELLNESS KITCHEN.*

_____ _____
CLIENT SIGNATURE DATE TWK STAFF SIGNATURE DATE

_____ _____
PRINT NAME PRINT NAME

Official Use Only Below
Mail Chimp___ Filed____ Client call list____ Allergy list____ Doctor notified____ Classes___ Wall___

HEALING FOODS ORDER HISTORY

Name:_____

WEEK OF:	ITEM	QUANTITY	COMMENTS / NOTES

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