



FLEAUX INTAKE FORM

PATIENT INFORMATION:

DATE: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ (H) _____ (C) _____

Date of Birth: _____ Age: _____ Sex: M / F

Email Address _____ Height _____ Weight _____

EMERGENCY CONTACT: Name: _____ Phone: _____

Allergies(Food or Medicine) _____

What are your main complaints? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Fatigue or low energy | <input type="checkbox"/> Asthma and Allergies |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Recent Surgical Procedure |
| <input type="checkbox"/> Poor diet due to busy lifestyle | <input type="checkbox"/> Recent illness |
| <input type="checkbox"/> Brain Fog or trouble concentrating | <input type="checkbox"/> Cold or flu symptoms |
| <input type="checkbox"/> Low mood or depression | <input type="checkbox"/> Facial wrinkles or fine lines |
| <input type="checkbox"/> Headaches or migraines | <input type="checkbox"/> Dull or dry skin |
| <input type="checkbox"/> Weight gain or difficulty losing weight | <input type="checkbox"/> Malabsorption issues |
| <input type="checkbox"/> Slow metabolism | <input type="checkbox"/> other |

Which statements best describe why you are here today? (Please check all that apply)

- I want to have more energy and feel better overall
- I want to do everything I can to nourish my body
- I want to do everything I can to enhance my weight loss efforts
- I want to prevent getting sick
- I want to recover quickly from my surgery or illness
- I want to slow the aging process
- I want to feel and look younger
- I want to have smoother, brighter and more vibrant skin
- I want to cleanse my body of toxins
- I want to recover quickly from a hangover
- Other _____



MEDICAL HISTORY

Are you pregnant or breastfeeding? Yes / No

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?
(Please check all that apply)

- Hypermagnesemia (High magnesium levels)
- Hypercalcemia (High calcium levels)
- Hypokalemia (Low potassium levels)
- Hemochromatosis (High iron levels)
- Other _____

Are you a diabetic? Yes / No

Are you a smoker? Yes / No If yes, how much and when did you start?_____

Do you drink? Yes / No If yes, how much in a week?_____

Do you take any recreational drugs? Yes / No

Do you take any diuretics or water pills? Yes / No. Do you take diuretics or water pills? Yes / No

Do you take steroids, i.e. Prednisone? Yes / No

Do you have any of the following conditions? (Please check all that apply)

- Blood pressure problems (high or low)
- Heart Problem's
- Stroke or “mini-stroke”
- Kidney Problems
- Kidney Stones
- Asthma
- Vision Problems(Glaucoma, Optic Nerve Atrophy, Leber’s Disease
- Sickle Cell Anemia
- G6PD Deficiency
- Thyroid Problems



List any other medical conditions you have not mentioned.

List all surgical procedures.
