Functional Weight Loss Practitioner | Yoga Teacher
sunshineyogabyeva@gmail.com
973-873-1301

FUNCTIONAL MEDICINE CLIENT INTAKE FORM – FUNCTIONAL WEIGHT LOSS

Client Information
Full Name: _____
Date of Birth: _____ Age: _____ Sex: □ M □ F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Occupation: _____
Emergency Contact: _____ Phone: _____

Goals & Expectations

1. What are your primary goals for seeking functional weight loss support?

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2. What is your target weight or body composition goal?

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3. How soon would you like to achieve your goal?

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4. Have you previously worked with a functional medicine or integrative provider? □ Yes □ No

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5. **How committed are you to weight loss on a scale of 1 to 10?**
   (1 = not committed at all, 10 = fully committed)

Medical History

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Please list any diagnosed health conditions (e.g., hypothyroidism, PCOS, diabetes, insulin resistance):

Current Medications (include dosage & reason):

Current Supplements (include dosage & frequency):

Known allergies or food sensitivities:

History of surgeries or major hospitalizations:

Weight History & Lifestyle

1. Weight History

- Current weight: _____ Height: _____
- Heaviest adult weight: _____ Age: _____
- Lowest adult weight: _____ Age: _____
- Have you experienced significant weight fluctuations? □ Yes □ No
  If yes, please explain: _____

2. Diet History

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- Describe your current eating habits (typical meals, snacks, etc.):
- Describe your current alcohol and coffee habits (daily/weekly)

- Have you followed any specific diets in the past? (e.g., keto, low-carb, vegan)

- Do you track calories or macronutrients? □ Yes □ No

3. Digestive Health

- How often do you have a bowel movement? _____ per day/week
- Any digestive symptoms? (e.g., bloating, gas, reflux, constipation)
  □ Yes □ No If yes, describe: _____

4. Physical Activity

- Frequency of exercise: _____
- Type of activity: _____
- Do you enjoy physical activity? □ Yes □ No

5. Sleep & Energy

- Hours of sleep per night: _____
- Sleep quality: □ Excellent □ Good □ Fair □ Poor
- Do you wake rested? □ Yes □ No
- Daily energy levels (1–10): _____

6. Stress & Mental Health

- Stress level (1–10): _____

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- Primary sources of stress: _____
- Do you experience emotional eating or binge eating? □ Yes □ No
- Have you been diagnosed with depression or anxiety? □ Yes □ No

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Hormonal Health (if applicable)

- Female: Are your periods regular? □ Yes □ No If NO explain:

- Any history of PCOS, endometriosis, or hormonal imbalances? □ Yes □ No if YES explain:

- Male: Any issues with libido, muscle mass, or mood? □ Yes □ No if YES explain:

Functional Medicine Assessment

1. Do you experience any of the following?
□ Sugar cravings
□ Fatigue after meals
□ Brain fog
□ Difficulty losing weight despite diet/exercise

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□ Cold hands/feet
□ Hair thinning or hair loss
□ Dry skin
□ Frequent urination or thirst
□ Mood swings
□ Poor motivation or low drive

2. Have you had recent lab work? □ Yes □ No
Please attach or bring copies of labs including: CBC, CMP, HbA1c, Lipid Panel, Thyroid Panel, Hormones, CRP, Vitamin D, etc.

Client Agreement & Signature

I understand that this intake form is for informational purposes and to guide my care under a functional medicine approach. I acknowledge that this is not a substitute for medical diagnosis or treatment from a licensed physician.

Privacy Statement

Your personal data will be treated confidentially and will not be shared with third parties. The information provided here is solely used for personalized consultation purposes.

Client signature: _____ Date: _____

Please complete and return this form at least 24 hours before your scheduled consultation.
You can send it to the following email address:
sunshineyogabyeva@gmail.com