Client Intake Form: Depression, Anxiety, and Stress Evaluation

Client Information

- **Name:**
- **Date:**
- **Age:**
- **Gender:**
- **Occupation:**

Symptom Evaluation (Past Week)

Please rate how much the following statements applied to you over the past week:
0 = **Did not apply to me at all**
1 = **Applied to me to some degree or some of the time**
2 = **Applied to me a considerable degree or a good part of the time**
3 = **Applied to me very much or most of the time**

Depression

1. I felt downhearted and blue.
2. I couldn't seem to experience any positive feelings.
3. I found it difficult to work up the initiative to do things.
4. I felt I was worthless.
5. I felt that life was meaningless.

Anxiety

6. I experienced trembling (e.g., in hands).
7. I felt close to panic.
8. I felt scared without any good reason.
9. I was aware of dryness in my mouth.
10. I experienced difficulty breathing (e.g., excessively rapid breathing, breathlessness).

Stress

11. I felt that I was using a lot of nervous energy.
12. I found it difficult to relax.
13. I felt irritable or over-reactive.
14. I felt that I was intolerant of interruptions or delays.
15. I found myself getting agitated.

Functional Medicine Factors

Lifestyle and Environment

- How many hours of sleep do you get per night?
- Do you wake feeling rested? (Yes/No)
- Do you exercise regularly? (Yes/No)
  - If yes, what type and how often?
- Do you currently feel overwhelmed by your responsibilities? (Yes/No)
- Have you experienced any major life changes or stressful events recently? (Yes/No)

Diet and Nutrition

- How would you describe your daily diet? (Poor, Average, Excellent)
- Do you consume caffeine? (Yes/No) If yes, how much per day?
- Do you consume alcohol? (Yes/No) If yes, how often?
- Have you experienced recent changes in appetite or weight? (Yes/No)
    - If yes, please describe.

Gut-Brain Connection

- Do you experience regular digestive issues? (Yes/No)
- Have you noticed a link between your mood and certain foods? (Yes/No)
    - If yes, please describe.

Energy Levels

- Do you experience energy fluctuations throughout the day? (Yes/No)
- When do you feel your best and worst during the day?

Supplements and Medications

- Are you currently taking any medications or supplements? (Yes/No)
    - If yes, please list them.
- Have you noticed any changes in mood since starting or stopping a medication/supplement?

Additional Notes

Please share any additional information you feel is important regarding your emotional health, lifestyle, or recent experiences: