Anita Sadaty, MD
Redefining Health

Optimize Your Health In 60 Minutes
Quick Fix Intake Form

Top Three Symptoms / Concerns — How Long Has Each Been Going On?

1. _____ _____
2. _____ _____
3. _____ _____

What Medical Issues Do You Have?

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do You Have Any Of The Following Symptoms? *Circle All That Apply:*

GAS BLOATING CONSTIPATION DIARRHEA BURPING HEARTBURN REFLUX
NAUSEA IBS HEADACHES MIGRAINES BRAIN FOG PMS MEMORY ISSUES
HOT FLASHES NIGHT SWEATS LOW LIBIDO HEAVY PERIODS FIBROIDS
CYSTIC BREASTS ENDOMETRIOSIS CANCER

Medications / Supplements Are You Currently Taking? (use additional page if needed)

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

What Do You Eat On A Typical Day? (Be specific!)

Breakfast: _____ Lunch: _____
Dinner: _____ Snacks: _____
How Many Snacks Per Day? _____
How Much Caffeine? (Cups/Day) _____ How Much Alcohol? (Glasses/Week) _____
What Do You Typically Drink To Hydrate? (Glasses/Day) _____

What Exercise Do You Do? _____
How Many Hours Per Week Do You Exercise? _____ Do You Feel Invigorated Or Tired Afterwards? _____

Sleep: Restful or Disrupted? _____ Do You Wake Up Refreshed Or Tired? _____
What Is Your Bedtime? _____ When Do You Wake Up? _____ Hours Of Sleep Per Night? _____

What Do You Do For Work? _____

What Are Your Top Three Most Stressful Things In Your Life Currently?

1. _____ 2. _____ 3. _____