

Your Custom Rx Intake Form

Name: _____

DOB: _____

Date: _____

Supplements: Put a ✓ in the “Yes”, “No” or “Interested In Including” box for any supplements you take or would like to take. In the last column, write the name of the manufacturer, product name, how often, and how much you take. Fill out additional rows as needed. **The “Interested In” box indicates interest in including that product into your current protocol.*

If you do not take any supplements put a ✓ in the “I Do Not Take Any Supplements” Box listed below

I Do Not Take Any Supplements

	Yes	No	Interested In Including	Manufacture Name / Product Name How Much? How Often?
Example: Multi-Vitamin	✓			Orthomolecular, Mitocore 2 caps/twice daily
Multi-Vitamin				
B-Complex				
Calcium / Bone Health Product				
GI Support				
Vitamin D				
Magnesium Product				
Fish Oil				
Fiber				
Probiotic				
Adrenal Support				
CoQ 10				
Natural Anti-Inflammatory				
Glucosamine / Joint Product				
Immune Support Products				
Glutathione / Anti-Oxidant Support				
Herbal Product				
Liver/ Detoxification				
Amino Acids				
Blood Sugar Support Product				
5 HTP / GABA / Neurotransmitter Product				
Enzymes				
Biotin / Skin Hair Nails Product				
Zinc / Other Single Minerals				
Vitamin C / Other Single Vitamins				

