Intake Form

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In order to best support your wellness, it is imperative to have a good understanding of your history. Please take your time and address the following questions with as much clarity as possible.
This form will be kept confidential. All information herein will not be released to any person without your permission.
Successful client/herbalist relationships are only possible when the practitioner has a full understanding of their client's physical, mental, emotional, and spiritual well being. However, if there are questions that you find difficult to answer, or would prefer not to answer, feel free to talk to me about this. Remember your response will go a long way in assisting my understanding of you, so please take your time in addressing them. Your honesty and attention to detail are greatly appreciated.

Name:..... **Date:** ……

Address: ……..
City, State, and Zip code: ……..
Phone: Home ……..... Cell …….
Email Address: ……..
Best way to contact you: ……...
Date of Birth: …….. Age: ……. Male/Female: ……...
Height: ……Weight: …….
Relationship Status: …….. Children: ……..
Occupation: ……...

List your major health concerns starting with the ones you feel need the most attention. Also please include the amount of time you have been dealing with this situation as well as the overall severity (from 1 to 10 – 1 being "never noticeable" to 10 being "utterly unbearable"):
1. …….
2. …….
3. …….
4. …….

When did these conditions begin? What were the circumstances surrounding the onset of these conditions?

……
……
……

List all the medications/drugs, vitamins, minerals, herbs, etc. you currently take (both prescription and non-prescription) as well as their current dosages:

1. ……...
2. ……...
3. ……...
4. ……...
5. ……...
6. ……...
7. ……...
8. ……...
9. ……...
10. ……...

Are you sensitive or allergic to anything including vitamins, minerals, prescription drugs, foods, household chemicals, pets, or general environmental substances?
Yes ….. No ….. If yes, please list and describe the severity of your allergic reaction:

……
……
……
……
……

Practitioners

Are you currently under the care of a healthcare practitioner? Please note which of the following types of health care practitioners you have seen. Use **'P**' if you have seen them in the past and '**C**' if you are currently under their care.

….. Acupuncture
….. Chiropractic
….. Counseling
….. Physical therapist
….. Homeopath
….. Naturopath
….. Psychiatrist
….. Psychologist
….. Massage Therapist
….. Medical doctor (type): …….
……..
Other (please specify): ……..

LIFESTYLE

How would you describe your overall general health?

…….
…….
…….

What are the predominant emotions you experience (i.e. anger, frustration, happiness, sadness, grief)?
…….
Are any emotional issues present with family, work, and social relationships?
…….
…….
How would you describe the level of stress in your life (home, work, other)?
…….
…….
Do you exercise? Yes ….. No …..
If yes, what form(s) and how often?
…….
…….
Do you have an unusual susceptibility to heat or cold? Do you feel warmer or colder compared to people around you?
…….
…….
Do you perspire easily?
…….
Do you make time for rest, relaxation, or meditation during the day and/or before bed? Yes ….. No ….. How often and how do you relax?
…….
…….
What are your interests or hobbies: ……...
…….

Do you use:

	Now	**In the Past**	**Type**	**Amount/per week For how long**
Tobacco:	……	……..	……..	……..
Alcohol:	……	……..	……..	……..
Coffee:	……	……..	……..	……..
Cannabis:	……	……..	……..	……..
Recreational Drugs:	……	……..	……..	……..

HEALTH HISTORY

Please list all major health issues/illnesses/diseases experienced during your lifetime and at what stage of development they happened:

……
……
……
……
……
……
……

Please list major surgeries with approx. dates:

……
……
……
……
……

What is your ancestry: ……... Blood Type: …….

Please list any major health issues/illnesses/diseases in your blood relatives:

Mother: ……..
Father:……
Siblings: …….
Grandparents: ……..
Children: ……

DIET

How would you describe your appetite and thirst? ……...
……..
How many meals do you eat each day? ……....
Do you:
Eat out often ….. Diet frequently ….. Skip meals frequently ….. Cook own food …..
Where do you shop for your food? …….
Do you pay attention to organic and/or non-GMO foods? Yes ….. No …..
Do you have any special diet/eating restrictions? Yes ….. No …..
If yes, please explain: ……..
……
……
List the primary foods you include in your diet: ……
……
……
List the foods you exclude from your diet: ……

……
……
List any foods to which you have a bad reaction: ……
……
Mark which of these you consume regularly and how much daily or weekly:

Coffee …….. ……..	Alcohol ……..
Sugar/Sweets …….....	Dairy …….
Wheat …….....	Fast food ……..
Processed foods ……...	Artificial sweeteners …….

List any foods cravings and/or aversions: ……..
……
How much water do you drink daily? …….
What temperature do you prefer to drink? Hot ….. Cold ….. Room temperature …..
Do you ever have a particular taste in your mouth (salty, sweet, bitter, metallic, etc.), especially in the mornings? …….
……
Do you experience afternoon hot flashes and/or night sweats? ……..
……

Please make a list of your typical eating habits/food intake for three full days (see table on the last page)!

SLEEP

What time do you go to sleep? …… What time do you wake up? ……..
Do you have trouble falling asleep? Yes ….. No …..
If yes, what keeps you up? ……..
……
……
Do you wake at night and have trouble getting back to sleep? Yes ….. No …..
If yes, what time do you usually wake? ……..
In the morning, do you wake feeling refreshed? Yes ….. No …..
Do you have recurring dreams? Yes ….. No …..
If yes, what is the theme? ……....
……

GENERAL

In a normal day when do you feel your energy level is at its peak? …….
What time of day is your energy the worst? ……...
Do you feel tired after you have eaten? Yes ….. No …..

Please mark which applies best with regards to your overall wellness. Please cross out which option is the worst:

Winter	Spring	Summer	Autumn
Cold	Heat	Dampness	Dryness
Staying put	Traveling	Ocean	Mountains
Morning	Evening	Physical exertion	Mental exertion
Open Air	Inside		

Other things that make you significantly better or worse: ……
…….
How often and when have you taken antibiotics? …….
…….

For the following questions, write '**P**' for problems you have experienced in the past, '**R**' for recurring problems, and '**O**' for problems that are occurring occasionally.

RESPIRATORY

Number of colds/flu in the past year: ……..

….. Difficult Breathing	….. Bronchitis	….. Pneumonia
….. Shortness of Breath	….. Runny nose	….. Phlegm/Congestion
….. Chronic Cough	….. Asthma	….. Rattling Sound With Breathing
….. Acute Cough	….. Wheezing	….. Swollen Tonsils
….. Yellow or Green Sputum	….. White Sputum	….. Unproductive, Dry Cough
….. Difficulty in breathing, esp. when lying down		….. Dry Mouth and Throat
….. Burning Sensation in palms, soles and chest		….. Feeling of Heat in the afternoon
….. Night Sweats	….. Horse Voice	

Additional information: ……..
……

CARDIOVASCULAR

….. Cold Hands and Feet	….. Edema	….. High Blood Pressure
….. Palpitations	….. Blood Clots	….. Low Blood Pressure
….. Dizziness Upon Standing	….. Tightness In Chest	….. Pain In Chest
….. Rapid Heart Rate	….. Slow Heart Rate	….. Irregular Heart Rate
….. Bruise easily	….. Fainting	….. Pacemaker
….. Excessive Dreaming	….. Easily Startled	….. Mental Restlesness

….. Mouth or Tongue Ulcers ….. Feeling of Heat ….. Red and Flushed Face
….. Feeling of Stuffiness/Discomfort in Heart Region
Additional information: ……..
…….

HEAD, EYES, EARS, NOSE, AND THROAT

….. Poor Vision	….. Blurred Vision	….. Glasses/Contacts
….. Poor Hearing	….. Night Blindness	….. Eye Pain
….. Itchy Eyes	….. Glaucoma	….. Cataracts
….. Spots in Vision	….. Ear Ringing	….. Hearing Loss
….. Ear Infections	….. Earaches	….. Concussions
….. Headaches	….. Itching in Ears	….. Sores on Mouth
….. Nosebleeds	….. Congestion	….. Sinus Infections
….. Sore Throat	….. Throat Tickle	….. Swollen Glands
….. Lump in Throat	….. Enlarged Thyroid	….. Root Canals in Teeth
….. Chapped Lips	….. Teeth Grinding	….. Teeth Removed
….. Numerous Cavities	….. Gum Problems	….. Excessive Saliva
….. Facial Pain	….. Facial Numbness	….. Sinus Problems
….. Lump or Plum-Pit Feeling in the Throat		….. Sour Belching

Additional information: ……..
…….

SKIN AND HAIR

….. Dry Skin and/or Hair	….. Hair Loss	….. Hair Breaking
….. Oily Skin and/or Hair	….. Dandruff	….. Acne
….. Rashes	….. Itching	….. Eczema
….. Psoriasis	….. Fungal Infection	….. Premature Graying
….. Excessive Sweating	….. Hives	….. Dry Nails
….. Skin Changes	….. Warts	….. Thin Slow Growing Nails

Additional information: ……..
…….

MUSCULOSKELETAL

….. Joint Instability	….. Muscle Weakness	….. Lower Back Pain
….. Joint Pain	….. Muscle Cramps	….. Stiffness
….. Joint Swelling	….. Muscle Spasm	….. Muscle Weakness
….. Weak Bones	….. Muscle Pain	….. Arthritis
….. Chronic Pain	….. Acute Pain	….. Weak Knees

Additional information: ……..
…….

NERVOUS SYSTEM

Average hours of sleep a night: ……..

….. Drowsiness	….. Obsessive Thinking	….. Stress

….. Seizures ….. Melancholy/Depression ….. Rapid Mood Changes
….. Nerve Pain ….. Headaches ….. Loss of Balance
….. Stroke ….. Poor Quality Sleep ….. Anxiety
….. Forgetfullness and Poor Memory ….. Trouble Falling Asleep
….. Numbness or Tingling ….. Inappropriate Anger
Additional information: ……..
……

URINARY TRACT
….. Urinary Tract Infections ….. Kidney Infection ….. Kidney Stone
….. Painful Urination ….. Sediment in Urine….. Frequent Urination
….. Inability to Hold Urine ….. Blood in Urine ….. Recent Change in Flow
….. Nighttime Urination ….. Dribbling ….. Dark Yellow Urine
….. Bed Wetting ….. Light Yellow Urine
Additional information: ……..
……

REPRODUCTIVE
….. Sexually transmitted disease: ……..
….. Feeling Excessive Sexual Drive ….. Lack of Sexual Drive
Male:
….. Premature Ejaculation ….. Pain on Intercourse/Ejaculation
….. Prostate Pain ….. Pain/Swelling in Testicles
….. Impotence ….. Difficulty Getting an Erection
Female:
Length of cycle: …… Duration of bleeding: .....
Birth control (if used):.....
….. Menstrual Pain ….. Infertility ….. Menopause, if yes, age: …….
….. Cysts/Fibroids ….. Breast Lumps ….. Pain with Intercourse
….. Vaginal Pain ….. Vaginal Itching ….. Vaginal Discharge
….. Vaginal Odor ….. Heavy Bleeding ….. Irregular Cycle
….. Amenorrhea ….. Blood Clots, if yes, what size and color: ……..
….. Miscarriages # …… ….. Pregnancy # ……
PMS:
….. Emotional ….. Anxiety ….. Moodiness
….. Cravings ….. Bloating/Swelling ….. Cramping
….. Breast Tenderness
Additional information: ……..
……

DIGESTION
…..Poor Appetite …..Hiccups …..Extreme Hunger/Cravings
…..Bloating …..Bad Breath …..Eat to Calm Down
…..Low Blood Sugar …..Indigestion …..Intestinal Pain

…..Heartburn	…..Acid Reflux	…..Use Antacids
…..Gallstones	…..Ulcers	…..Nausea
…..Stomach Rumbling	…..Gas/Flatulence	…..Diarrhea
…..Vomiting	…..Constipation	…..Use Laxatives
…..Rectal Pain/Itching	…..Vomiting Blood	….. Hemorrhoids
…..Mucus in Stool	…..Blood in Stool	…..Undigested Food in Stool

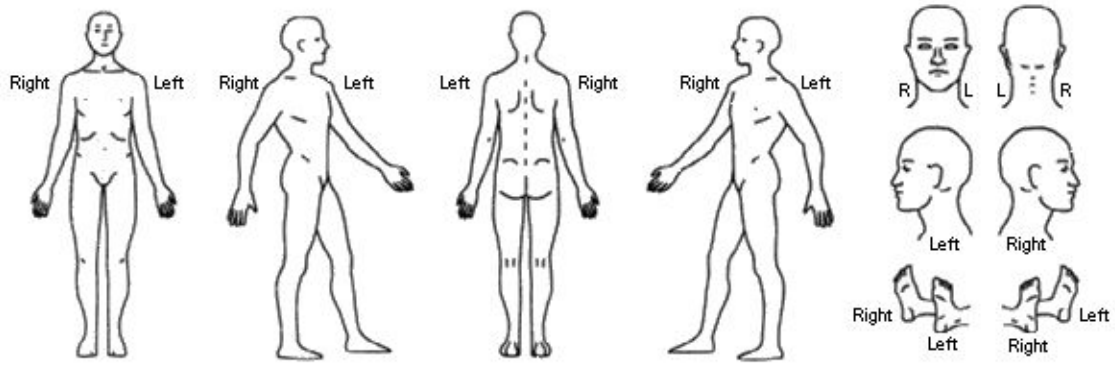
…..Alternating Diahrrea and Constipation

Number of bowel movements in an average day (or week if not daily) ……..
Please circle your stool type (or describe based on chart below), and detail the color, odor, and if it sinks or floats:
……..
……
……

Additional information: ……..
……

PAIN CHART

If you have recurring pain, please circle the locations where pain is experienced most frequently.



In case of a phone consultation please attach the following to the intake form:

- Picture of your tongue (both sides)

- Measurement of heart rate taking in the morning (beats per minute)

Typical Diet

	DAY 1	DAY 2	DAY 3
Breakfast			
Lunch			
Dinner			
Snacks			
Beverages (water, tea, coffee, wine etc.)			