Herbal and Wellness Intake Form-New Client Questionnaire

Please fill out the form below, being as honest and thorough as possible. Your answers will allow me to make the best clinical assessment that I can. Allow 30-45 minutes to complete the intake form. This is the information we will review in depth during our initial consultations. Remember, nobody is judging. I want to assist you as best I can and not telling the truth will only hinder your progress.

Today's Date ___________________

Name____

Address____

Telephone: Day____________________ Night_____________________ Is it alright to leave a message and is it pertinent that I be discreet?______

E mail:___________________________________

Emergency Contact: _____________________________ Best way to contact you:_____________________________

Date of Birth _________ Age_____ Place of Birth____

Height & Weight _____________________________

Where and when have you lived or traveled outside the U.S. and Canada?

____

Passions/Interests: ____

____

Occupation ______________________________ How long_______________ Relationship Status:_________________

What are your primary reasons for this consultation?

1.____

2.____

3.____

What other health-related issues do you have/have you had in the past?

____

____

____

Are you currently working with any other health care practitioners? ____________________________________

____

Family

Relationship	*Alive/Deceased*	*Present health or cause of death*
Father	_____________	____
Mother	_____________	____
Brothers	_____________	____
Sisters	_____________	____
Children/ages	_____________	____
	_____________	____

Is there anything else you would like to share about your family? ________________________________

Have you or any blood relatives had any of the following? ***(Circle those that apply to family members, check those that apply to you)***

☐ Allergy/Asthma	☐ Headaches/Migraines	☐ Stroke
☐ Arthritis	☐ Heart Disease	☐ Substance abuse
☐ Bleeding/Clotting Tendency	☐ High Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Kidney Disease	☐ Tuberculosis
☐ Diabetes	☐ Obesity	Other:

Please check boxes & indicate how often you use the following (daily, weekly, monthly, etc)

❍ Dairy products	❍ Soy products	❍ Fruits
❍ Soft drinks	❍ Fish	❍ Alcohol
❍ Juice	❍ Canned food	❍ Raw or cooked mushrooms
❍ Margarine	❍ Bakery goods	❍ Red Meat and poultry
❍ Butter	❍ Nuts & Seeds (which ones)	❍ Fried foods
❍ Coffee	❍ Vegetables	❍ Water
❍ Tobacco	❍ "junk food" types:	❍ Artificial sweeteners/sugar

How often do you eat at restaurants? ________________ How often do you cook/prepare food? ________________

How many meals do you eat a day? __________________ How often do you snack & when? ______________________

Do you eat often after 7 PM and if so how often? ____

What foods do you crave? ____

What beverages do you crave? ____

Do type of water do you drink (tap, bottled, filtered, etc.)?

How do you feel about food? ____

Are you allergic or sensitive to any substances? ____

Have you had lengthy exposure to environmental toxins? ____

Do you follow or have you ever followed a restricted diet? Which one(s)?

____

____

Please indicate an example of (1) your diet when have time and energy to prepare meals and (2) a typical diet when stressed or pressed for time. Please include beverages.

(1): Breakfast	Lunch	Dinner	Snack (time of day)
(2): Breakfast	**Lunch**	**Dinner**	**Snack (Time of day)**

Medications currently or previously used (Over the counter and prescription)

Name	Dosage / Frequency/Duration	For what reason are you taking this?

Supplements/vitamins/herbs currently used

Name	Dosage / Frequency/Duration	For what reason are you taking this?

General Health Questions

Highest weight as an adult: ______ Year: _____ Lowest weight as an adult: ______ Year: _________
Are you satisfied with your energy levels? Yes Sometimes No
Do you have regular bowel movements? Yes No
How many bowel movements do you have per day? _________ Per week? ____________
Is it ever difficult to move your bowels? Yes No Sometimes

Typical hours spent watching TV per day ________ Typical hours on the computer per day ________
Exercise –type/frequency/for how long____

____

Typical bedtime ___________________ Typical hours asleep _________ Do you feel rested upon waking?
____
Are you satisfied with your primary relationship and/or your support system?_____________________________________
On a scale from 1 (low) to 10 (high), how stressful is your: Work?_____ Health status?______ Social/family situation? _________
What would you describe as the dominant emotions in your life right now?

____

Reproductive History

For Men and Women:

Are you currently sexually active? _______

Forms of birth control used (Mark C for currently, and P for past)

__ Oral contraceptives
__ Diaphragm
__ Fertility Awareness
__ IUD
__ Tubal ligation/vasectomy
__ Patch
__ Condoms
__ Withdrawal
__ Other (specify): ___________

For Women:*

Have you experienced any of the following:

__ breast abnormalities	__ ovarian cysts/PCOS	__ vaginal dryness
__ endometriosis	__ painful intercourse	__ vaginal infection
__ fibroids	__ painful orgasm	
__ low libido	__ sexually transmitted disease	

Have you ever had an abnormal Pap smear? __ Yes __ No

If yes, please provide the date(s): ____

What steps were taken as a result? ____

Are you now pregnant? ______

Are you actively trying to conceive? ______ How long have you been trying? ______

Are you currently breastfeeding? _____

Are you currently on hormone replacement therapy (HRT)? _______ Have you ever been on HRT? _____

Do you currently do a monthly breast self-exam? __________

Date of last menstrual period: _____________

Pregnancies *(please include losses/terminations)*

Year	Vaginal/C section	Sex	Complications/Other things you want to mention

*** If you discover that you are pregnant during the course of our work together, please discontinue all herbal supplements and schedule an appointment so that we can discuss your herbal options.***

For men:

__ blood in semen	___ urinary dribbling	__ pain or swelling in testicles
__ burning on ejaculation	___sexually transmitted disease	__ penis discharge
__ low libido	___vasectomy	__ painful orgasm/ intercourse
__ prostate pain		

Have you experienced any of the following?

Is it ever difficult to get your urine flowing?______

Do you often have trouble achieving or maintaining an erection?______

In each row, please read across the three columns and circle the box(es) that best describe you. You may circle more than one box per row.

General	Need solitude when stressed	Need action when stressed	Need people when stressed
	Variable energy	Consistent high energy	Slow to start
	Tendency toward being cold	Tendency toward being warm	
	Love to travel	Action oriented	Love to stay home

	Lose weight easily	Maintain weight easily	Gain weight easily
Mind	Live in future	Live in present	Live in past
	Creative	Bold, Courageous	Calm
When stressed, tendency toward-	Fear/anxiety	Quick to anger	Despondency
	Difficulty focusing	Focused mind	
	Emotions difficult to control	Controlled emotions	Not much variance in emotions
	Variable sleep	Deep, but short sleep	Deep sleep
	Wake easily	Generally wake refreshed	Generally waking is difficult
	Love privacy	Love risk and adventure	Love affection and approval
Memory:	Good short-term; poor long-term	Detail oriented	Good long-term; poor short-term
Renal/Bladder	Frequent dizziness on standing/ low blood pressure		
	Frequently thirsty (fluids "run right through")	Hot weather aggravates urinary symptoms	Infrequent thirst
	Urgent need to urinate when nervous	Infrequent urination in hot weather	
	Urine almost always clear	Urine usually yellow	Urine often cloudy
	Frequent urination		Urinate infrequently; large volume
	Prefer moist environment		Prefer dry environment
	Crave salt		Feel worse when using salt
Respiratory	Respiratory tract easily irritated by dry air		Respiratory. tract feels better with spicy food
	Respiratory tract easily irritated by smoke/irritants	Respiratory. symptoms worse in hot air/environments	Respiratory. symptoms worse in cool/damp air
	Nasal passages often feel dry	Respiratory tract feels inflamed ("hot, burning, irritated")	Nasal passages or sinuses feel full or swollen
	Shallow breather		Infection tends to settle in lungs
	Hyperventilate/forget to breathe when stressed	Frequent yellow or green mucus	Frequent clear/white mucus
Female Reproductive	Menses irregular	Menses predictable	Constipation before menses
	Sharp, stabbing cramps	Loose stools with menses	Pressing, dull, aching cramps
	Fatigue with menses		Water retention before menses
	Menses starts with red blood		Menses starts with brown blood/spotting
Skin	Skin is cool & dry	Skin is warm & moist	Skin is cool & moist
	Skin is thin & flaky	Skin is firm	Skin is soft & smooth
	Dry hair & scalp	Thin hair, tends toward oily, may have receding hair line	Thick, shiny hair
	Lips chap easily		
	Nails brittle/cracked	Soft, flexible nails	Strong, thick nails

	Burn easily in sun	Tan easily in sun	
	Skin is worse in winter	Skin is worse in summer	Skin is worse in damp
		Skin is red & easily inflamed	
Gastrointestinal System	Variable appetite	Strong, demanding hunger	Predictable appetite
	Dry, pebbly stools	Loose and regular stools	Sluggish or regular bowels
	Alternating constipation/diarrhea	Burning sensation after eating	Feel heavy/stuck after eating
	Frequent gas, painful	Yellowish/light brown stools	Foul-smelling gas
	Quick defecation after eating	Think of food as fuel to keep going	Eat to calm down
	Difficulty digesting heavy foods	Strong digestion	
	Need to eat frequently		Feel good on only one or two meals a day
	Often forget to eat		
Cardiovascular	Rapid, erratic pulse	Strong pulse	Slow pulse, steady
	Cold hands & feet	Feels warm/ hot most of the time	Tendency toward edema, stagnation
	Difficulty adjusting to temperatures		
	Heart palpitations when stressed		
	Frequent low blood pressure		
Immune	Complete exhaustion when ill	Attempt to work through illness	Take time off for slightest hint of illness
	Recuperation from illness variable	Recuperate quickly after illness	Recuperate slowly after illness
	Inflammation comes and goes	Easily inflamed, resolves quickly	Inflammation resolves slowly
		Arthritis worse with heat	Arthritis/rheumatism worse with cold

Please check anything you have noticed in the past year. Any issues that you had previously, but no longer have, mark with a "P"

__ Bruise easily	__ Frequent cold sores	__ Incontinence	__ Respiratory issues
__ Chemical sensitivity	__ Frequent diarrhea	__ Lyme Disease	__ Seizures
__ Chest pains	__ Frequent gas	__ Memory Loss	__ Sinus Infections
__ Chronic fatigue	__Gum problems	__Nausea	__ Shingles
__ Depression	__ Hearing issues	__ Night sweats	__ Skin rashes
__ Digestive issues	__ Heart palpitations	__ Nose bleeds	__ Swollen glands
__ Earaches	__ Heartburn/GERD	__Numbness	__ Tinnitus (ringing in ears)
__ Eczema/Psoriasis	__ Low blood sugar	__ Phobias	__ Ulcers
__ Fainting		__ Poor concentration	__ Urinary tract infection

Please list major events in the last ten years of your life and the dates they occurred (include births, deaths, marriages, divorce, accidents, moves, jobs changes, miscarriages, illness and anything else you feel greatly impacted your life):

Date/Event

Do you drink alcohol? Yes No
How often? Daily Weekly Monthly Socially Never
If you drink alcohol what type of alcohol do you enjoy the most? ____________________________

Have you ever tried any other drugs and if so which ones and for how long?

Favorite season and why:

Outlook on life:

Additional things you would like to mention: