Think well. Do well. Be well.

CONSULTATION INTAKE FORM

DATE ________________________ WEIGHT ____________ AGE __________ SEX __________

NAME ____

ADDRESS ____

CITY ____________________________________ STATE ______________ ZIP ___________

HOME PHONE __________________________ CELL PHONE ____________________________

E-MAIL ____ May we contact you? ☐ YES ☐ NO

- YOUR PERSONAL INFORMATION IS COMPLETELY CONFIDENTIAL -

GENERAL

Current Physical Complaints: ____

Onset and length of symptoms: ____

List any medications you are currently taking: ______________________________________

List anything else we should know: ____

List any herbal medicines, supplements or over-the-counter medications you are currently taking/have recently taken:

MEDICATION	REASON FOR USE	DOSAGE	TIMES PER DAY

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PAST MEDICAL HISTORY

Surgeries: ____

Serious Injuries: ____

Allergies: ____

____

Current Weight ______________ Weight 1 Year Ago _______________ Weight 5 Years Ago ________________

GENERAL

Do you have or have had any of the following?

☐ High Blood Pressure	☐ High Cholesterol	☐ Heart Problems	☐ Urinary Tract Infections
☐ Kidney Problems	☐ Fainting Spells	☐ Frequent Cold or Flu	☐ Wounds Heal Slowly
☐ Acne	☐ Eczema	☐ Skin Rashes	☐ Asthma
☐ Fatigue	☐ Swollen Lymph Nodes	☐ Cancer	☐ Anorexia/Bulimia
☐ Hepatitis	☐ Diabetes	☐ Migraines	☐ Anxiety
☐ Sinus Problems	☐ Lung Problems	☐ Insomnia	☐ Depression

How do you usually get sick or experience bodily distress? (digestive, respiratory, reproductive, etc.)

____

How often does this happen? ____

FAMILY HISTORY

List any medical conditions or problems in family members:

____

____

____

____

LIFESTYLE

Tobacco Use ☐ YES ☐ NO ☐ PAST How much and how often: ______________________________

Alcohol Use ☐ YES ☐ NO ☐ PAST How much and how often: ______________________________

Caffeine Use ☐ YES ☐ NO ☐ PAST How much and how often: ______________________________

Drug Use ☐ YES ☐ NO ☐ PAST How much and how often: ______________________________

How frequently do you exercise? Daily _____________ Weekly ________________ Rarely _____________

Type of exercise: ____

DIGESTION

Appetite: ☐ Good ☐ Fair ☐ Poor Digestion: ☐ Good ☐ Fair ☐ Poor

Do you experience bloating or gas after meals? ______________________________

Do you feel sleepy or tired after meals? ______________________________

Are you on a restricted diet? ☐ YES ☐ NO Explain: ______________________________

When is the last time you took antibiotics? ______________________________

Do you feel agitated or low function if you don't eat regularly? ______________________________

ELIMINATION

How often do you have a bowel movement? Daily __________ Times per week _____________ Irregular _____________

Do you ever have hard stools? ____________________ Do you ever have loose stools? ____________________

Urination: ☐ Normal ☐ Scanty ☐ 5+ times daily ☐ Burning ☐ Strong Odor ☐Dark Color

How many glasses of water do you drink daily? ______________________________

Any history of bladder or kidney infections? ______________________________

WOMEN'S HEALTH

Do you experience any of the following - past or present?

☐ Breast Pain ☐ Irregular PAP ☐ Fibroids ☐ Endometriosis ☐ Difficulty Conceiving
☐ Hot Flashes ☐ Difficult Menopause ☐ Currently Pregnant ☐ STDs including HIV ☐Vaginal Dryness
☐ Ovarian Cysts ☐ Vaginal Infections ☐ Irregular Cycles ☐ Pelvic Pain ☐ No Menstruation

MENSTRUAL CYCLE

How many days do you menstruate? ____________________ Spotting before or after period? ☐ YES ☐ NO

Do you have clots? ☐ YES ☐ NO Clot Size ____________________ Number of Clots ______________

Color of Menstrual Blood: ☐ Bright Red ☐ Maroon ☐ Brown Volume of Menstrual Blood: ______________

MEN'S HEALTH

- ☐ Frequent Urination
- ☐ Reproductive Issues
- ☐ Prostate Problems
- ☐ Painful Urination
- ☐ Other: ______________________________

STRESS LEVEL

What would you rate your level of stress (0=no stress, 10=maximum stress)? ____

What are the major sources of stress in your life? ____-_____

Do you have ways to deal with stress? ____

How many hours of sleep do you get on an average night? ______________

Do you have any sleep issues? ☐ Insomnia ☐ Extreme Fatigue Please explain: ____________________________________

Do you usually wake up feeling tired or rested? ____

Nerves: ☐ Good ☐ Fair ☐ Poor

Anxiousness: ☐ Often ☐ Sometimes ☐ Seldom

Depression: ☐ Often ☐ Sometimes ☐ Seldom

RECOMMENDED FOLLOW UP

☐ Complicated Health Issues: 1-2 Weeks ☐ Moderate Health Issues: 2-4 Weeks ☐ Healthy Follow Up: As Needed

PLEASE NOTE

We do not diagnose or prescribe. Our services are strictly educational, offering clients the tools to enhance their own wellbeing and help them make educated decisions about their own health care. Herbal therapeutics are not meant to replace medical diagnosis or treatment. If symptoms persist, please contact your doctor.

I understand and agree to the above terms.

____ ______________________________

CLIENT SIGNATURE DATE