Client Intake Form

Please complete and return this comprehensive health form no later than 24 hours prior to our appointment. I realize it might take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, as well as about your current medical concerns and reasons for seeking my help. Having all this information on paper will be very helpful when we meet, and we will review this together during your consultation. Information provided on this form will be held in strict confidence.

GENERAL INFORMATION:

Name: ____ Age: ______________

Date of Birth: _______________________ Email: _____________________________________

Address: ____

Phone # you wish to be contacted at: ______________________

Can I leave you a message at this number? ◯ Yes ◯ No

Height: ________________ Weight: ________________ Weight one year ago: ______________

Who do you share a home with? ____

Occupation: _____________________________How many hours a week do you work? ___________

Are you currently under the care of a health care 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.

___ Ayurvedic practitioner ___ Naturopath ___ Psychiatrist ___ Medical doctor

___ Chiropractor ___ Social Worker ___ Psychologist ___ Other

___ Counseling ___ Massage therapist ___ Spiritual Counselor

___ Occupational therapist ___ Herbalist ___ Traditional Chinese Medicine Doctor

___ Acupuncturist ___ Physical therapist ___ Homeopath

HEALTH GOALS

1. When was the last time you felt really well?

2. Did something trigger your change in health? Do you have any insights or hunches into what's going on with your health?

3. What, if anything, makes you feel better?

4. What makes you feel worse?

5. What will a successful outcome look like to you and in what timeframe?

YOUR HEALTH STORY

Please rank your current and ongoing health concerns in order of priority:

Describe Problem **Severity:**	**Mild**	**Moderate**	**Severe**	**Prior Treatment** **Approach Success:**	**Excellent**	**Good**	**Fair**
Example: ***Post Nasal Drip***	x			*Elimination diet*	x		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

MEDICATIONS AND SUPPLEMENTS

Current medications / vitamins / herbs / supplements (please list the names, dosages, and what you are taking them for. For supplements with multiple ingredients, please take pictures of the labels and attach to this document):

Medication/Supplement/Herb	Dose and duration of use	Reason

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, Ibuprofen), Motrin, or Aspirin? **Y / N**

Have you had prolonged or regular use of Tylenol/acetaminophen? **Y / N**

Have you had prolonged or regular use of opioid pain killers? **Y / N**

Have you had prolonged or regular use of proton pump inhibitors (PPI) or antacids? **Y / N**

Have you had frequent or prolonged courses of antibiotics (> 3 times per year, or for > 2 weeks)? **Y / N**

FAMILY HISTORY

Please note any history of the following conditions within your biological family: fibroids, endometriosis, PCOS, miscarriage, stillbirth, clotting disorder, heart disease, cancer, stroke, high blood pressure, lung disease, kidney disease, diabetes, mental illness/addiction, autoimmune conditions, and any other significant illness/condition.

Family Member:	Health Condition:	Deceased?

Known familial genetic disorders:

YOUR HEALTH HISTORY

Have you ever been formally diagnosed by a licensed physician with any of the following? Check all that apply.

- ◯ AIDS
- ◯ Angina
- ◯ Arthritis (rheumatoid)
- ◯ Arthritis (osteo)
- ◯ Arrhythmia (irregular heartbeat)
- ◯ Asthma
- ◯ Attention Deficit Disorder (ADD/ADHD)
- ◯ Autoimmune disorder, specify: ______________________
- ◯ Benign Prostatic Hyperplasia (BPH)
- ◯ Bleeding disorder
- ◯ Cancer, specify: _________________________
- ◯ Cardiac Arrest (Heart attack)
- ◯ Celiac Disease
- ◯ Chronic Fatigue
- ◯ Chronic Obstructive Pulmonary Disorder (COPD)
- ◯ Cirrhosis of the Liver
- ◯ Colitis
- ◯ Crohn's Disease
- ◯ Congestive Heart Failure
- ◯ Depression / Anxiety
- ◯ Diabetes
- ◯ Hypoglycemia
- ◯ Eating Disorder
- ◯ Epilepsy
- ◯ Fatty Liver Disease
- ◯ Fibromyalgia
- ◯ Gallstones
- ◯ Gout
- ◯ Graves' Disease (hyperthyroid)
- ◯ Hashimoto's Disease (thyroiditis)
- ◯ Hypothyroidism (low thyroid function)
- ◯ Hepatitis
- ◯ Hypertension (high blood pressure)
- ◯ Immune Deficiency
- ◯ Interstitial Cystitis
- ◯ Irritable Bowel Disease
- ◯ Kidney Stones
- ◯ Lupus
- ◯ Metabolic Syndrome / Insulin Resistance
- ◯ Mitral Valve Prolapse
- ◯ Mood Disorder, specify: _________________________
- ◯ Multiple Sclerosis
- ◯ Obsessive-Compulsive Disorder
- ◯ Osteoporosis
- ◯ Parkinson's Disease
- ◯ Peptic Ulcer Disease
- ◯ Psoriasis / Eczema
- ◯ Sexually Transmitted Infections (STIs)
- ◯ Sleep Apnea
- ◯ Stroke
- ◯ Ulcers
- ◯ Other, specify: _________________________

CURRENT SYMPTOMS

Please check √ if the following symptoms occur presently or have occurred in the last 6 months:

Glandular / Endocrine Function

- ◯ Burning sensation in hands and/or feet
- ◯ Cold intolerance
- ◯ Dark circles under eyes
- ◯ Dry skin
- ◯ Daytime sleepiness
- ◯ Difficulty falling asleep
- ◯ Early waking
- ◯ Excess weight around abdomen
- ◯ Fatigue in the afternoons
- ◯ Fatigue, chronic or excessive
- ◯ Feeling chronically stressed
- ◯ Feeling exhausted or "burned out"
- ◯ Fever
- ◯ Frequent thirst
- ◯ Hair loss or thinning
- ◯ Heat intolerance
- ◯ Lack of stamina
- ◯ Low body temperature, easily chilled
- ◯ Mental sluggishness, "brain fog"
- ◯ Mood swings
- ◯ Muddled thinking, confusion
- ◯ Night waking
- ◯ Nightmares
- ◯ Weight gain or loss

Head, Eyes, & Ears

- ◯ Conjunctivitis (pink eye)
- ◯ Distorted sense of smell / taste
- ◯ Ringing or buzzing in ears
- ◯ Eye pain
- ◯ Headache / migraine
- ◯ Hearing problems or loss
- ◯ Sensitivity to light
- ◯ Sensitivity to loud noises
- ◯ Vertigo
- ◯ Vision problems

Skin & Structural System

- ◯ Acne
- ◯ Arthritis
- ◯ Back pain
- ◯ Chronic muscle tension
- ◯ Eczema
- ◯ Gout
- ◯ Itching skin
- ◯ Leg cramps or pain
- ◯ Chest tightness
- ◯ Joint deformity
- ◯ Joint hypermobility
- ◯ Joint pain / redness / stiffness
- ◯ Multiple root canals
- ◯ Muscle pain / spasms / stiffness / twitches
- ◯ Muscle weakness
- ◯ Neck tension
- ◯ Osteoporosis
- ◯ Rashes
- ◯ Restless leg syndrome
- ◯ Rosacea
- ◯ Teeth grinding
- ◯ TMJ problems

Mood/Nerves

- ◯ Absent-mindedness
- ◯ Anxiety / nervousness
- ◯ Auditory or visual hallucinations
- ◯ Blackouts
- ◯ Depression
- ◯ Difficulty falling asleep
- ◯ Difficulty with concentration or memory
- ◯ Difficulty with thinking or speech
- ◯ Difficulty with balance or coordination
- ◯ Dizziness or light-headedness
- ◯ Excitability, difficulty relaxing
- ◯ Fearfulness or paranoia
- ◯ Irritability / short-tempered
- ◯ Numbness or tingling
- ◯ Panic attacks
- ◯ Seizures
- ◯ Suicidal thoughts
- ◯ Tremor or trembling

Please check √ if the following symptoms occur presently or have occurred in the last 6 months:

Circulatory System

- ◯ Anemia
- ◯ Angina / chest pain
- ◯ Breathlessness
- ◯ Gingivitis or gum disease
- ◯ Heart attack
- ◯ Heart murmur
- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Irregular pulse / arrhythmia
- ◯ Palpitations
- ◯ Phlebitis (inflammation of the veins)
- ◯ Raynaud's syndrome
- ◯ Swollen ankles/feet
- ◯ Varicose veins or spider veins / hemorrhoids / varicocele

Urinary & Fluid System

- ◯ Bladder infection
- ◯ Blood in the urine
- ◯ Burning or painful urination
- ◯ Difficulty starting urination
- ◯ Excessive perspiration
- ◯ Frequent urination
- ◯ Night sweats
- ◯ Pain in the mid to low back
- ◯ Puffiness under the eyes
- ◯ Scant, dark urine
- ◯ Urinary incontinence (dribbling)
- ◯ Water retention or edema
- ◯ Swollen lymph nodes

Respiratory System

- ◯ Chronic or frequent cough
- ◯ Cold sores
- ◯ Excess mucus production
- ◯ Frequent infections
- ◯ Hayfever and respiratory allergies
- ◯ Itchy nose or ears
- ◯ Post-nasal drip
- ◯ Sinus headaches
- ◯ Sinusitis or chronic sinus congestion
- ◯ Wheezing or shortness of breath

Male Reproductive System

- ◯ Difficulty with urination
- ◯ Erectile dysfunction
- ◯ Infertility
- ◯ Lack of sex drive
- ◯ Loss of self-confidence and drive
- ◯ Nighttime urination
- ◯ Pain in the testes
- ◯ Prostate problems

Any other concerns:

Digestive System

- ◯ Abdominal pain or discomfort
- ◯ Acid indigestion, heartburn, or acid reflux
- ◯ Bad breath
- ◯ Bloating, belching, or intestinal gas
- ◯ Constipation (bowel movements less than once per day)
- ◯ Cravings for sugary foods
- ◯ Diarrhea or loose stools
- ◯ Food allergies, specify: __________________
- ◯ Food sits heavy on stomach after meals
- ◯ Groggy feelings in the morning
- ◯ Hard, dry stools
- ◯ Hemorrhoids or anal fistula
- ◯ Loss of appetite or poor appetite
- ◯ Mucus or undigested food in stool
- ◯ Sensation of lump in the throat
- ◯ Underweight or unable to gain weight

NUTRITION

Do you currently follow any of the following special diets or nutritional programs? (check all that apply)

◯ Vegetarian	◯ Low Fat	◯ Dairy free	◯ Keto
◯ Vegan	◯ Low Carb	◯ Gluten free	◯ Macrobiotic
◯ GAPs/FODMAP	◯ Blood Type	◯ Kosher	◯ Other:
◯ Elimination	◯ Low Sodium	◯ Paleo	

How would you rate the quality of your nutrition over the past month? (1=very poor, 5=excellent)
◯ **1** ◯ **2** ◯ **3** ◯ **4** ◯ **5**

Do you have sensitivities to certain foods?

Do you have an aversion to certain foods?

Do you experience adverse reactions to caffeine?

Do you experience symptoms immediately after eating, such as burping, bloating, sneezing, hives, etc?

Do you eat three meals a day? **Y / N** If no, how many?

Does skipping a meal greatly affect you? **Y / N**

How many meals do you eat out per week? ◯ **0-1** ◯ **1-3** ◯ **3-5** ◯ **>5 meals per week**

Check the factors that apply to your current lifestyle and eating habits:

- ◯ Fast eater
- ◯ Eat too much
- ◯ Late-night eating/snacking
- ◯ Dislike healthy foods
- ◯ Travel frequently
- ◯ Eat more than 50% of meals away from home
- ◯ Shift-worker
- ◯ Healthy foods not readily available
- ◯ Poor snack choices
- ◯ Significant other or family members don't like healthy foods
- ◯ Significant other or family members have special dietary needs
- ◯ Love to eat
- ◯ Eat because I have to
- ◯ Have negative relationship to food
- ◯ Struggle with eating issues
- ◯ Emotional eater (eat when sad, lonely, bored, etc)
- ◯ Eat too much under stress
- ◯ Eat too little under stress
- ◯ Don't care to cook
- ◯ Confused about nutrition advice

Was your childhood diet similar to your present one? **Y / N**

Do you have a history of dieting? In other words, have you repeatedly followed one or more diets for weight loss or health? **Y / N**

Do you currently have or are you in recovery from an eating disorder? **Y / N**

Allergies

Do you have any allergies?

Which medicines (including herbs) have you taken for them?

When and where are your allergies least and most troublesome?

Do you have any allergic reactions to any pharmaceutical or herbal medicines?

What has most helped your allergies?

Lifestyle

What do you currently do to relax / manage stress?

How many hours of sleep do you get per night? ___________ Do you wake feeling rested? **Y / N**

Are you satisfied with your energy levels? **Y / N / Sometimes**

When is the high point and low point of your daily energy levels?

Have your energy levels changed markedly at any point recently or in your past? **Y / N**

What preceded this change?

What are significant stressors for you currently?

Have you had any serious injuries?

Hospitalizations / surgeries:

Do you smoke or chew tobacco? Y / N Are you exposed to second-hand smoke? Y / N

Do you currently use cannabis? Y / N

Do you currently use any illegal recreational drugs? Y / N

Activity

	Low Intensity	Moderate Intensity	High Intensity	How Often?
Stretching/yoga				
Cardio/Aerobics				
Strength Training				
Sports or Outdoor Recreation				
Walking				

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at first period: ______________________ Date of last period: _____________________________

Length of cycle: _________________________ # of days of bleed: _____________________________

Are you ovulating regularly? How do you know? (eg. Do you notice a change in cervical mucus mid-cycle, use LH strips, track basal body temperature, etc.?)

Do you experience any spotting/bleeding between periods? **Y/N** How many days? ______________

Would you consider your flow on your heaviest day to be:

- ◯ Extremely heavy
- ◯ Heavy
- ◯ Medium
- ◯ Light
- ◯ Very light
- ◯ Not sure

Are you in menopause? **Y / N** If yes, age at last period: ______________________
Was it surgical menopause? **Y / N**

Are you on hormone replacement therapy? **Y / N**
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?

Menstrual / Menopausal Symptoms

- ◯ Night sweats
- ◯ Hot flashes
- ◯ Amenorrhea / irregular cycles
- ◯ Bloating / water retention
- ◯ Cravings
- ◯ Pelvic pain/cramps
- ◯ Irritability / anxiety
- ◯ Brown blood
- ◯ Clotting
- ◯ Acne
- ◯ Breast tenderness
- ◯ Breast lumps/cysts
- ◯ Heavy bleeding
- ◯ Concentration/memory problems
- ◯ Headaches/migraines
- ◯ Vaginal dryness
- ◯ Pain with intercourse
- ◯ Decreased libido
- ◯ Difficulty reaching orgasm
- ◯ Urinary incontinence

Are you currently trying to conceive? **Y / N**

Current or Past Use of birth control (write a "C" for current use or "Past" for past use):

- ◯ Birth control pills
- ◯ Nuva Ring
- ◯ Mirena IUD
- ◯ Copper IUD
- ◯ Contraceptive patch
- ◯ Fertility Awareness Methods
- ◯ Barrier methods
- ◯ Tubal ligation/partner vasectomy
- ◯ None

Other Gynecological Conditions (write a "C" for current use or "Past" for past use):

- ◯ Endometriosis
- ◯ Infertility
- ◯ Fibrocystic breasts
- ◯ Vaginal infection
- ◯ Fibroids
- ◯ Ovarian cysts
- ◯ Painful intercourse
- ◯ Polycystic Ovary Syndrome
- ◯ Pelvic Inflammatory Disease
- ◯ Reproductive cancer
- ◯ Sexually transmitted infection

Date of last PAP test: _________________________ Result: ___________________________________
Other tests/procedures:

Obstetric History

# of pregnancies: ___________ Miscarriages: ________________ Abortions: ___________________
# of live children: ____________________

Are you currently lactating? **Y / N**
Did you develop any problems during or after pregnancy, for example, pre-eclampsia (high blood pressure), diabetes, post-partum depression, issues with breast-feeding, etc? If yes, explain:
Please add any additional information you feel may be helpful in evaluating your situation.

READINESS ASSESSMENT

Rate how willing you are, on a scale of 1 (not willing) to 5 (very willing), to:

Significantly modify your diet	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**
Take herbs or nutritional supplements as recommended	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**
Keep a food journal periodically	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**
Modify your lifestyle (ie. Work demands, sleep habits)	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**
Practice a daily relaxation technique	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**
Engage in regular exercise	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**

As part of our work together, are you interested in:

◯ Dietary recommendations
◯ Herbal recommendations
◯ Supplement recommendations
◯ Coaching and motivational support

How often do you anticipate needing/wanting to schedule appointments?

◯ I prefer to meet every 2 – 3 weeks to keep myself accountable and check in
◯ I anticipate needing to follow up every month or two
◯ I just want a second pair of eyes on my plan; I don't anticipate needing additional support after the first two visits
◯ Not sure/whatever is recommended
◯ Other: ____

When it comes to herbs and supplements: (please check all that apply)

◯ I prefer not to take herbs/supplements
◯ I am on a very tight budget and need to keep costs as low as possible
◯ Price is not an issue; I want the best option for me regardless of cost
◯ I am open to using herbal teas/infusions
◯ I am open to taking capsules or tablets
◯ I am open to using herbal tinctures (alcohol-based liquid extracts)
◯ If it doesn't taste good, I'm not likely to take an herbal tea or tincture
◯ I have an extensive herbal apothecary already
◯ I prefer to make my own herbal products when possible
◯ I have a garden and grow/am interested in growing herbs
◯ I prefer to incorporate herbs in to my foods when possible

Thank you for sharing all this personal and important information with me.
Everything you share is completely confidential.
I look forward to helping you reach your health and personal goals!