High Priestess Herbal Care

Herbal Wellness Intake Form

All information is confidential and used solely for creating a personalized herbal and spiritual wellness plan.

Full Name:

Date: DOB: Age:

Phone Number: Email Address:

Preferred Method of Contact: Phone / Text / Email

Emergency Contact Name & Phone:

GENERAL INFORMATION

What are your primary health concerns or goals at this time?

How long have you been experiencing these issues?

Have you seen a doctor or alternative practitioner for this? If yes, who and when?

Do you have any current health conditions?
□ Yes □ No
If yes, please describe:

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Are you currently taking any medications or supplements?
□ Yes □ No
If yes, please list them:

Any known allergies (especially to herbs, plants, oils, foods)?

Are you pregnant, nursing, or trying to conceive?
□ Yes □ No

How is your digestion?
□ Excellent □ Good □ Fair □ Poor

Any issues (bloating, gas, constipation, etc.)?

How is your sleep?
□ Restful □ Interrupted □ Insomnia □ Vivid Dreams

Do you wake up feeling refreshed?
□ Yes □ No

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LIFESTYLE & DAILY HABITS

What is your current occupation?

How would you describe your daily stress level?
☐ Low ☐ Moderate ☐ High ☐ Very High

What do you currently do for stress relief or emotional support?

Do you use any of the following substances? (Check all that apply)
☐ Tobacco ☐ Alcohol ☐ Caffeine ☐ Cannabis ☐ Other: _____

Emotional Well-being:
□ Balanced □ Anxious □ Depressed □ Overwhelmed □ Grieving □ Other:

MENSTRUAL & WOMB HEALTH (IF APPLICABLE)

Do you currently menstruate? □ Yes □ No
Cycle length: _____ days | Flow: □ Light □ Moderate □ Heavy
Any symptoms? (cramps, PMS, clots, irregularity):

History of womb trauma, fibroids, PCOS, etc.:

Do you engage in yoni steaming, womb care, or feminine rituals?
□ Yes □ No □ Curious to start

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Herbal Experience

Have you worked with herbs before?
□ Yes, regularly □ Occasionally □ Brand new

Preferred herbal forms:
□ Tea □ Tincture □ Capsules □ Poultice □ Steams □ Baths □ Smokes □ Oils

How consistent are you with routines or rituals?
□ Very consistent □ Somewhat □ Needs structure

ENERGETIC & SPIRITUAL INSIGHT

Do you work with spiritual practices (e.g. meditation, energy healing, ancestor work)?
□ Yes □ No
If yes, briefly share what you do or feel drawn to:

Are you open to spiritual or intuitive recommendations?
□ Yes □ No

Any past spiritual trauma or practices to avoid?

Lifestyle Snapshot
Typical Diet:

How much water do you drink daily?

How is your stress level?
□ Low □ Moderate □ High

Any recent major life changes (grief, birth, loss, moves, etc.)?

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SYMPTOM & CONDITION CHECKLIST

Please check any of the following that currently apply to you or have applied in the past.

GENERAL HEALTH

- □ Fatigue / Low Energy
- □ Chronic Pain
- □ Headaches / Migraines
- □ Allergies
- □ Frequent Illness / Weak Immune System
- □ Dizziness / Vertigo
- □ Fever / Night Sweats
- □ Cold Hands / Feet
- □ Weight Changes (Unexplained gain or loss)
- □ Autoimmune Disease (please specify): _____
- □ Cancer (past or present)
- □ Diabetes (Type 1 / Type 2)
- □ Thyroid Imbalance (Hyper / Hypo)

MENTAL & EMOTIONAL WELL BEING

- □ Anxiety
- □ Depression
- □ Mood Swings
- □ Panic Attacks
- □ Brain Fog
- □ Trouble Concentrating
- □ PTSD / Trauma
- □ Insomnia / Difficulty Sleeping
- □ Grief / Heartbreak
- □ Low Motivation

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SYMPTOM & CONDITION CHECKLIST

Please check any of the following that currently apply to you or have applied in the past.

HEART & CIRCULATION

- Heart & Circulation
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Heart Palpitations
- □ Poor Circulation
- □ Varicose Veins

DIGESTIVE HEALTH

- □ Bloating
- □ Constipation
- □ Diarrhea
- □ Acid Reflux / Heartburn
- □ IBS / Crohn's / Colitis
- □ Nausea / Vomiting
- □ Gas / Cramping
- □ Food Sensitivities or Intolerances

Respiratory & Immune

- □ Asthma
- □ Sinus Congestion
- □ Chronic Cough
- □ Seasonal Allergies
- □ Bronchitis / Respiratory Issues

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SYMPTOM & CONDITION CHECKLIST

Please check any of the following that currently apply to you or have applied in the past.

REPRODUCTIVE & WOMB HEALTH

- □ Irregular Menstrual Cycle
- □ Heavy Bleeding / Clots
- □ Painful Periods
- □ PMS / Mood Shifts
- □ Fibroids
- □ PCOS
- □ Endometriosis
- □ Fertility Concerns
- □ Menopause / Perimenopause Symptoms
- □ STIs / Infections (past or current)
- □ History of Womb Trauma / Loss
- □ Low Libido / Sexual Disconnection

SPIRITUAL & ENERGETIC CONCERNS

- □ Feeling Spiritually Disconnected
- □ Blocked Creativity / Intuition
- □ Nightmares / Sleep Disturbance
- □ Feeling Heavy / Unclear
- □ Ancestral Grief / Lineage Trauma
- □ Energy Leaks / Feeling Drained
- □ Difficulty Grounding
- □ Seeking Clarity or Purpose

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Medications & Other Concerns

Please list any current medications, vitamins, supplements, or over-the-counter remedies you are taking:
(Include dosage and reason, if known)

_____

_____

_____

Do you have any known allergies (including herbs, foods, or medications)?

- □ No
- □ Yes → Please list:

_____

_____

_____

Do you have any of the following sensitivities?

- □ Caffeine
- □ Alcohol
- □ Smoke / Incense
- □ Essential Oils / Scents
- □ Certain Foods (please list): _____
- □ Other: _____

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Are you currently pregnant, trying to conceive, or breastfeeding?

- □ No
- □ Yes → Please explain:

_____

Is there anything else you would like to share about your health, trauma history, or intentions for this herbal consultation or cleanse?

(This is a safe, confidential space to include any spiritual, emotional, or energetic information you'd like held in consideration.)

_____

_____

_____

Intentions & Goals

What do you hope to receive from this herbal/spiritual support?

Signature

I understand that the information shared is for holistic wellness purposes and does not replace medical advice from a licensed healthcare provider. I take full responsibility for my healing journey.

Signature: _____

Date: _____