Dr. Linda Kingsbury
Herbalist & Holistic Health Educator
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CLIENT HEALTH HISTORY

Name date
Address
City, State, Zip email
Phone # daytime evening
Birthdate Place
Work/Occupation/Student
How long at current position Do you like it?
Last medical exam Physician
Current/recent medications

Past/present medications taken for more than 1 year

Current nutritional supplements/herbs

Are there any healers or therapies you are currently involved in?

Are you receiving support from a mental health counselor?
Have you seen one in the past? Was it helpful?

FOCUS
Are you currently experiencing health challenges?

How are the following areas of your life are affected?
Physical body

Mental thought patterns

Emotions/feelings

Spiritual Fulfillment

Social life
In your sessions would you like me to focus on:
Herbs & nutritional support?
Prevention & Well Living Skills?

MEDICAL HISTORY

Height_____Weight_____Are you happy with your body?_____
Allergies_____
_____
Operations_____
_____
Hospitalizations_____
_____
Women
PMS/Menopausal symptoms_____
Other_____
Men
Prostate/reproductive problems_____
other

Health of your parents

Health of your partner/spouse_____
Do you have any children _____Ages_____Do they live with you_____
Health of your Children

LIIFESTYLE

How do you feel about the foods you eat?_____
_____
Do you have any food or other cravings?_____
_____
Addictive behaviors? past_____
Present_____
Current use and frequency of:
caffeine_____nicotine_____alcohol_____marijuana_____
What type of exercises do you do?_____
_____
Do you sleep well?_____
_____
Where does the stress in your life come from?_____
_____
_____
What do you do for fun/hobbies/recreation?_____
_____
Religious affiliation_____
Spiritual Practices_____
Favorite Season_____
Pets

Is there anything else that would be helpful for me to know as I guide you to build your health naturally?_____
_____
_____

DAILY INTAKE

Please fill out the form below for 3-5 days and bring to your appointment. Use as many pages as it takes.

Time of Day	Please list all Medications – Vitamin Supplements – Foods Snacks - Beverage Intake	How you are feeling emotionally at the time of ingestion