**Patient MINI Intake Form** (this form allows for typing)

***Please note: this mini intake is used only for quick onset, minor but bothersome conditions affecting your health (colds, congestion, allergies, UTI, etc). Longer onset or chronic conditions require a full intake f*orm and a longer appointment duration.**

DATE:

NAME (First/MI/Last)

DATE OF BIRTH/ AGE

MALE/FEMALE:

HEIGHT/WEIGHT

WEIGHT ONE YEAR AGO:

GENETIC BACKGROUND: African American, Asian, Caucasian, Mediterranean, Native American, Northern European, Other:

ADDRESS (FULL):

PRIMARY CONTACT PHONE NUMBER:

IS THIS A MOBILE PHONE THAT ACCEPTS TEXT? Y/N

CAN VOICEMAILS BE LEFT ON THIS PHONE? Y/N

EMERGENCY CONTACT PHONE:

EMAIL ADDRESS:

MARITAL STATUS: Single/Married/Divorced/Widowed

ANY CHILDREN OR OTHER DEPENDENTS LIVING IN YOUR HOME?

ARE YOU CURRENTLY EMPLOYED FULL TIME/PART TIME? If yes, please list average # of hours worked per week:

HAVE YOU TRAVELED OUTSIDE THE U.S. IN THE LAST TWO YEARS? If yes, add date, place and duration of travel.

**BRIEFLY LIST YOUR PRIMARY CONCERNS TODAY (What brought you here? what bothers you the most?) AND LIST SYMPTOMS/PAIN ASSOCIATED**

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| --- |
| Ex: Acid Reflux; nausea, burping, etc. |

**IN REFERENCE TO THE ABOVE COMPLETE THE FOLLOWING (cell will expand with typing):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Issue/Symptom  | Date of onset | Duration | Any ideas on what caused this issue? | How are you caring for this issue currently?  |
| Ex: Acid Reflux  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please enter below the initial date of onset or “current” for any condition you have experienced in the past or are currently experiencing.**

|  |  |  |  |
| --- | --- | --- | --- |
| condition | date or current | condition | date or current |
| Diabetes |  | Epilepsy(seizures) |  |
| High blood pressure |  | Cataracts/Glaucoma |  |
| High cholesterol |  | Crohn’s disease |  |
| Hypothyroidism (Underactive) |  | Colitis |  |
| Hyperthyroidism (Overactive) |  | Anemia |  |
| Goiter |  | Jaundice |  |
| Cancer (type) |  | Hepatitis (type) |  |
| Leukemia |  | Stomach issues or peptic ulcers |  |
| Psoriasis/ Eczema |  | Kidney disease |  |
| Angina |  | Kidney stones |  |
| Heart murmurs |  | Gall stones |  |
| Other heart issues |  | Multiple Sclerosis |  |
| Pneumonia |  | Stroke |  |
| Asthma |  | Poor Hearing |  |
| Emphysema |  | Liver or Kidney diseases |  |
| COPD |  | Other (explain) |  |

**Please list all physicians, diagnosis, medications, Vitamins, supplements, or herbals.**

|  |  |  |  |
| --- | --- | --- | --- |
| Physician Name | Diagnosis and Date | Meds/Potency/Dosage | Supplements/Dosage |
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|  |  |  |  |
| Include any herbals you are currently taking: |  |

**Please list any food, drug or herbal/plant allergies**

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**PLEASE ADD ANY ADDITIONAL INFORMATION THAT YOU WOULD LIKE THE HERBALIST TO know.**

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