Intentional Healing, LLC

Herbal Clinic Initial Visit Client Intake Form

The following information will be used to help plan safe and effective herbal clinic sessions.
This information is confidential so please answer the questions to the best of your knowledge.

Personal Information

Name:_____ Date of initial visit:____/____ /_____

Preferred Name:_____ Preferred Pronoun: she/her he/him they/them other: _____

Address:_____ City:_____Zip:_____

Phone:_____(mobile/work/home) Email:_____

Occupation:_____ Date of Birth:____/____ /_____

Emergency contact:_____ Phone: _____

Physician:_____ Phone: _____

May I have permission to contact your health care provider(s) about your medical history? This is often helpful in determining the best and/or safest course of action. Please initial: Yes_____ No_____

Date of Last Complete Medical Exam:____/____ /_____ Referred by: _____

Lifestyle

Relationship Status: ❑ Single ❑ Married (# of times ____) ❑ Separated ❑ Partnered ❑ Widowed

Name of the significant people and pets in your life (significant other/spouse/partner, kids (with ages), pets, parents, siblings, close friends, business partner, etc.) _____

_____

Employer:_____ How long? _____

Do you like your work?_____ Why? _____ Education:_____

Work tasks:_____

Religious/Spiritual:_____ Organizations: _____

Social Activities/Hobbies:_____

Primary Health Concerns

What are your primary health concerns at this time?

Current Symptoms	Date of Onset	Circle One
_____	____/____/_____	Gradual / Abrupt
_____	____/____/_____	Gradual / Abrupt
_____	____/____/_____	Gradual / Abrupt
_____	____/____/_____	Gradual / Abrupt
_____	____/____/_____	Gradual / Abrupt

Describe how your present condition affects you in your relation to your:

Work: _____

Home: _____

Social: _____

Other: _____

Current Health

Do you exercise regularly and/or participate in any sports? ❑ Yes ❑ No
If yes, what kind of exercise/sports? How frequently? _____

Do you have any difficulty lying on your front, back, or side? ❑ Yes ❑ No
If yes, please explain _____

Do you sit for long hours at a workstation, computer, or driving? ❑ Yes ❑ No
If yes, please explain _____

Do you perform any repetitive movement in your work, sports, or hobby? ❑ Yes ❑ No
If yes, please explain _____

Do you experience stress in your work, family, or other aspect of your life? ❑ Yes ❑ No
If yes, how do you think it has affected your health? _____

How healthy and happy do you expect you should be? (Rate for 0% to 100%: _____
How healthy and happy are you now? (Rate for 0% to 100%: _____

Please indicate your goals for session: _____

Please mark with an "X" on the lines below if you are experiencing any of the following:

No Pain — Pain
0 _____ 10

No Tension — Tension
0 _____ 10

No Stiffness — Stiffness
0 _____ 10

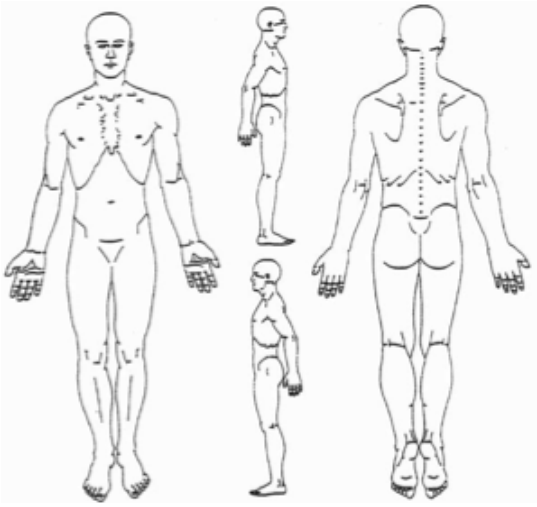
No Anxiety — Anxiety
0 _____ 10

No Insomnia — Insomnia
0 _____ 10

No Irritability — Irritability
0 _____ 10

Can Do Everything — Can't Do Anything
0 _____ 10

Please indicate on the body below the area where you are currently experiencing pain, tension and/or stiffness with the following marks: Pain X Tension 0 Stiffness S



Metabolic Screening Questionnaire

Please rate each of the following symptoms based upon your typical health profile for:

❑ Initial Test: The past 90 days ❑ Retest: The past 14 days ❑ Retest: The past 48 hours

Grading of Symptoms

0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
Total ____

Eyes
___ Swollen, reddened, or sticky eyelids
___ Blurred or tunnel vison (does not include near or far sightedness)
___ Bags or dark circles under eyes
___ Watery or itchy eyes
Total ____

Ears
___ Itchy ears
___ Earaches, ear infections
___ Ringing in ears, hearing loss
___ Drainage from ears
Total ____

Nose
____ Stuffy nose
____ Sinus problems
____ Sneezing attacks
____ Excessive mucus formation
____ Hay fever
Total ____

Mouth, Throat
____ Gagging, frequent need to clear throat
____ Sore throat, hoarseness, loss of voice
____ Swollen or discolored tongue, gums, lips
____ Chronic coughing
____ Canker sores
Total ____

Skin
___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flashes
___ Excessive sweating
Total ____

Heart
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total ____

Lungs
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
Total ____

Digestive Tract
____ Nausea or vomiting
____ Constipation
____ Bloated feeling
____ Belching or passing gas
____ Heartburn
____ Intestinal or stomach pain
____ Diarrhea
Total ____

Joints, Muscles
____ Stiffness or limitation of movement
____ Pain or aches in muscles
____ Feeling weakness or tiredness
____ Pain or aches in joints
____ Arthritis
Total ____

Weight
___ Binge eating, drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
Total ____

Energy, Activity
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
Total ____

Mind
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
____ Poor physical co-ordination
____ Difficulty making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning difficulties
Total ____

Emotions
____ Mood swings
____ Anxiety, fear, or nervousness
____ Anger, irritability, or aggressiveness
____ Depression
Total ____

Other
____ Frequent or urgent urination
____ Genital itch or discharge
____ Frequent illness
Total ____

Grand Total ____

Self-Evaluation Questionnaire

Please circle a number for each item according to your condition this week. Ask yourself: "How much improvement do I need in order to be healthy and happy?"

Job (answer even if unemployed) ----------	0	1	2	3	4	Answer key:
Living situation ----------	0	1	2	3	4	0 = I need no improvement
Spouse or partner (even if you have none) ----------	0	1	2	3	4	1 = I need little improvement
Family ----------	0	1	2	3	4	2 = I need moderate improvement
Friends ----------	0	1	2	3	4	3 = I need much improvement
Social life ----------	0	1	2	3	4	
Hobbies ----------	0	1	2	3	4	
Sex life (even if you're abstinent) ----------	0	1	2	3	4	
Religion, spirituality, philosophy, or meaning of life -------	0	1	2	3	4	
Ambition ----------	0	1	2	3	4	
Money ----------	0	1	2	3	4	
Self-confidence ----------	0	1	2	3	4	A _____
General health ----------	0	1	2	3	4	
Physical energy ----------	0	1	2	3	4	
Resistance to infection or ability to heal ----------	0	1	2	3	4	
Sleep ----------	0	1	2	3	4	
Appetite, digestion, or bowel function ----------	0	1	2	3	4	
Skin, lips, gums, or tongue ----------	0	1	2	3	4	
Breathing, cough, heart, or blood pressure ----------	0	1	2	3	4	
Joints, spine, aches, pains, or headache ----------	0	1	2	3	4	
Allergy, hay fever, asthma, or eczema ----------	0	1	2	3	4	
Sex function or menstrual function ----------	0	1	2	3	4	
Mental concentration ability ----------	0	1	2	3	4	
Memory for recent events ----------	0	1	2	3	4	B _____ A+ B _____
Anxiety or nervousness ----------	0	1	2	3	4	
Muscle tension or restlessness ----------	0	1	2	3	4	
Indecision ----------	0	1	2	3	4	
Worry ----------	0	1	2	3	4	
Fear or panic ----------	0	1	2	3	4	
Anger or temper outbursts ----------	0	1	2	3	4	
Resentment or hostility ----------	0	1	2	3	4	
Jealousy or envy ----------	0	1	2	3	4	
Loneliness ----------	0	1	2	3	4	
Withdrawal from people or seclusiveness ----------	0	1	2	3	4	
Boredom, meaningless, or not caring ----------	0	1	2	3	4	
Depressed mood or low spirits ----------	0	1	2	3	4	
Over-elated mood, too excited or high ----------	0	1	2	3	4	
Impulsive behavior or doing before thinking ----------	0	1	2	3	4	
Daydreaming ----------	0	1	2	3	4	
Putting things off or avoiding goals ----------	0	1	2	3	4	
Irritable, jumpy, or easily startled ----------	0	1	2	3	4	
Medication dependency ----------	0	1	2	3	4	
Alcohol, tobacco, marijuana, or narcotics (underline) --	0	1	2	3	4	c _____
Mental confusions ----------	0	1	2	3	4	
Mind dulled, slow, or blank ----------	0	1	2	3	4	
Thoughts racing or repeating ----------	0	1	2	3	4	
Thoughts too loud ----------	0	1	2	3	4	
Feeling unreal or strange ----------	0	1	2	3	4	
Feeling inferior ----------	0	1	2	3	4	
Feeling mistrustful or suspicious ----------	0	1	2	3	4	
Feelings deadened or nor feelings ----------	0	1	2	3	4	
Feeling hopelessness about self or life ----------	0	1	2	3	4	
Hearing voices, seeing visions, or hallucinations ----------	0	1	2	3	4	
Suicidal ideas or self-destructive urges ----------	0	1	2	3	4	
Homicidal ideas or destructive urges ----------	0	1	2	3	4	D _____ C+ D _____

Form developed by @ Howie Brounstein - Columbines School of Botanical Studies

Total _____

Constitutional Intake Questionnaire

Please place an X next to each of the following symptoms based upon your typical health profile for the past 30 days.

Upper GI

_____ Sometimes nausea in mornings
_____ Sometimes nausea in evenings
_____ Sometimes excessive salivation

Renal

_____ Standing too quickly makes pulse roar in ears
_____ Standing too quickly causes faintness/dizziness
_____ Wakes up at night to urinate

Health History

Please check any current and/or previous conditions that apply to you:

Musculoskeletal
- ❑ Bone or joint disease
- ❑ Tendonitis/Bursitis
- ❑ Arthritis/Gout
- ❑ Jaw Pain (TMJ)
- ❑ Lupus
- ❑ Spinal Problems
- ❑ Migraines/Headaches
- ❑ Osteoporosis
- ❑ Fractures

Circulatory
- ❑ Heart Condition
- ❑ Phlebitis/Varicose Veins
- ❑ Blood Clots
- ❑ High/Low Blood Pressure
- ❑ Lymphedema
- ❑ Thrombosis/Embolism

Respiratory
- ❑ Breathing Difficulty/Asthma
- ❑ Emphysema
- ❑ Allergies, specify _____
- ❑ Sinus Problems

Nervous System
- ❑ Shingles
- ❑ Numbness/Tingling
- ❑ Pinched Nerve
- ❑ Chronic Pain
- ❑ Paralysis
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease

Reproductive
- ❑ Pregnant, trimester _____
- ❑ Ovarian/Menstrual Problems
- ❑ Prostate

Skin
- ❑ Allergies, specify _____
- ❑ Rashes
- ❑ Cosmetic Surgery
- ❑ Athlete's Foot
- ❑ Herpes/Cold Sores

Digestive
- ❑ Irritable Bowel Disease
- ❑ Bladder/Kidney Ailment
- ❑ Colitis
- ❑ Crohn's Disease
- ❑ Ulcers
- ❑ Nausea

Psychological
- ❑ Anxiety/Stress Syndrome
- ❑ Depression
- ❑ PTSD

Other
- ❑ Cancer, specify _____
- ❑ Diabetes, type _____
- ❑ Stroke
- ❑ Aneurysm
- ❑ Seizures
- ❑ Inflammation/Swelling
- ❑ Communicable Disease
- ❑ Compromised Immune
- ❑ Cold/Flu/Fever
- ❑ COVID-19
- ❑ Easy Bruising
- ❑ Contact Lenses
- ❑ Dentures
- ❑ Hearing Aids
- ❑ Drug/Alcohol Use, frequency_____
- ❑ Tobacco Use, frequency_____
- ❑ _____

Please explain any of the health conditions indicated above: (has it been diagnosed by a health care provider?)

_____

_____

_____

Please provide information on the following (including type, approximate date and treatment):

Surgeries:_____

Major Illnesses: _____

Injuries/Accidents: _____

Please list any medication (including prescription, herbs, drugs, homeopathic remedies, vitamins, or supplements) you are currently taking (and their side effects) as it may affect the work that is performed:

_____

_____

Do you have any questions, concerns additional medical conditions, or information I should know about:

_____

_____

Physician:_____ Phone: _____

May I have permission to contact your health care provider(s) about your medical history? This is often helpful in determining the best and/or safest course of action. Please initial: Yes_____No

_____

Informed Consent

I verify that all the above information provided is correct and current to the best of my knowledge. I understand that I will be receiving massage/bodywork. I understand the practitioner is currently a licensed/certified massage therapist in the states of California and Oregon. That the practitioner has received training in the modalities she offers. If our session involves structural integration for the purpose of balancing and aligning the physical body so it is supported by gravity and moves with greater ease and freedom, I understand these sessions may include bodyreading, massage, manual therapy and movement therapy. I understand that the practitioner may not diagnose or treat injuries or diseases or prescribe medications and that this should not take the place of medical advice and/or treatment. I understand that either the practitioner or I can stop the session or alter the treatment plan at any time if either experience discomfort inappropriate for the situation. Discomfort may include (but not limited to) physical pain,

sexually suggestive behavior, personal remarks or requests. I expressly waive, release, discharge, and hold harmless Intentional Healing, LLC and the practitioner of any and all liability claims and demands, including attorney fees and costs, as a result of my participation in any activity of any type at Intentional Healing, LLC. I understand that all cancellations require 24-hour notice, or the full session fee may be charged (at the discretion of the practitioner). If I have any illness, injury or surgery, I will contact Intentional Healing, LLC so a decision can be made about rescheduling.

Signature:_____ Date:_____

Signature of parent or legal guardian (if client is a minor): _____