New Client Intake-Form

"True Holistic Herbalism goes beyond the use this herb for that symptom mindset. It sees the body not as a machine, but as a vital ecosystem – a reflection of nature. A garden that only needs the right kind of soil, sun, water, and air to operate in a healthy way."— Sajah Popum

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Please Note: I am not a licensed medical practitioner. Therefore, I am prohibited by law from diagnosing, prescribing for, or treating any condition. Recommendations discussed in our meetings are for educational purposes only, and consulting any new holistic/alternative protocol(s) with your primary care physician is advised. This form will be confidential, and any information collected will not be given to anyone without your permission.

This detailed intake form aims to assess your baseline constitution (where you are now, health-wise) and your known diagnosis/diagnoses and to search for any unattended and underlying conditions/ailments. These questions may or may not pertain directly to your condition. It is recommended that you fill this form in as much detail as possible. However, feel free to answer only the questions that pertain to you and that you think are important. Questions you would rather discuss in person can be marked (with an '*') for future one-on-one discussions.

General Information

Name:

Today's Date:

Phone #:

E-mail:

Birthdate:

Height:

Weight:

Occupation:

Gender:

Preferred Pronouns:

Children: Y / N

Qty: Ages:

Smoker: Y / N

Avg. number of cigarettes/joints per day:

Alcohol: Y / N

Avg. number of drinks per week:

Travel (average hours per week):

What is the main reason for your visit today? Western medical diagnoses (please attach any recent lab reports):

Current prescribed medication(s):

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Current Herbal Remedies & Supplements:

Previous Medication(s):

How many times a week do you cook at home/for yourself?

How many times a week do you eat out/take-away/delivery?

How many hours a week can you feasibly set aside for preparing food at home?

Do you follow a specific diet? (Veg/vegan, keto, paleo, intermittent fasting, etc.) How long have you been practicing this diet, and for what reasons?

Practitioners

Please note which of the following health care practitioners you have seen or are seeing. Use (P) if you have seen them in the past and (C) if you are currently under their care.

____Medical doctor (MD)
type(s): _____
____Acupuncture
____Ayurveda
____Occupational therapist
____Homeopath
____Counseling
____Physical therapist
____Psychiatrist
____Psychologist
____Chiropractor
____Naturopath
____Social Worker
____Spiritual counselor
____Traditional Chinese Medicine (TCM)
____Herbalist
____Bodywork
type(s): _____
____Other: _____

General Health

Please mark (P) for previous condition and (C) for current, and circle either (Y/N), (I/II), (A/B/C), etc. when applicable. You can always mark anything you are unsure of with a (?).

___AD(H)D
___Alcoholism
duration: _____
___Allergies/allergic reaction
type(s): _____
___Alzheimer's Disease
___Anemia
___Anxiety
___Arthritis (Rheumatoid)
___Asthma
___Auto-Immune conditions
type(s): _____
___Bursitis
___Cancer
type(s): _____
___Carpal tunnel syndrome
___Chronic Fatigue
___Chronic Pain
___Chronic Stress
___Common cold
___Constipation

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___Crohn's, Colitis, and/or IBS
___Depression
___Diabetes (I / II)
___Diarrhea
duration: _____
___Dizziness/Vertigo
___Drug abuse
type(s)/duration: _____
___Eating Disorder
type(s)/duration: _____
___Edema (fluid retention)
___Endometriosis
___Environmental sensitivities
___Epilepsy
___Epstein-Barr virus (Mono)
___Eyesight challenges
___Fertility Issues
___Headaches/Migraine
chronic: Y / N
___Heart disease/Heart attack
___Hepatitis (A / B / C)
___High blood pressure
___HIV/AIDS
___Huntington's Disease
___Hyperglycemia
___Hypoglycemia
___Indigestion (bloating, gas, diarrhea, stomach ache, etc.)
___Infection
type(s)/duration: _____
___Insomnia
duration: _____
___Lack of concentration
___Low blood pressure
___Low grade fever
___Lyme's Disease
___Male reproductive issues
___Memory loss
___Menopause
___Menstrual irregularities
___Muscle Strain/Repetitive Strain Injury (RSI)
___Nerve Pain/ Pinched Nerve
___Numbness in extremities
___Parkinson's Disease
___PCOS
___Psoriasis/Eczema/Rash
___Respiratory challenges/COPD
___Rosacea/Acne/skin blemish
___Seizures
___Sex Change and/or HRT
date/type(s): _____
___Shingles
___Shortness of breath
___Sick often
___Surgery (recent or pending)
date: _____
___Swollen lymph glands
___Tendonitis
___Thyroid condition(s) (Graves', Hashimoto's, Hyper-/Hypo)
type(s): _____
___Tinnitus and/or Deafness
___Urinary Tract Infection
chronic: Y / N
___Other: _____

Diet

Please fill in the below chart using the following scales:

F – Frequently (daily or more)
S – Sometimes (a few times a week)
I – Infrequently (generally less than once a week)
D – Do not consume this

___Alcohol
type(s): _____
___Caffeine
type(s): _____
___Meat
type(s): _____
___Dairy
type(s): _____
___Dairy-free milks/creamers
type(s): _____
___Eggs
___Fast-food/Fried foods
___Fermented foods
___Fruit (raw)
___Fruit (dried/cooked)
___Grains
type(s): _____
___Herbal teas
type(s): _____
___Honey/Maple/Agave/Alternative Sweeteners
___Juice
type(s): _____
___Nuts/seeds
type(s): _____
___Legumes
type(s): _____
___Processed foods
___Refined flour
___Refined sugar
___Saturated fats
___Seafood
type(s): _____
___Seaweeds
___Soda
___Soy
type(s): _____
___Spices
___Sweets
___Supplements
type(s): _____
___Vegetables (raw)
___Vegetables (cooked)
___Wheat gluten
___Organic
___Local (grown within a 50-90mi radius of where you reside)
___Seasonal Eating

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Describe your typical daily meals. Please be as specific as possible.

Breakfast:

Dinner:

P.M. snack(s):

A.M. snack(s):

Daily water intake (# of glasses/ounces per day): ____

Lunch:

Is your main water source bottled, filtered, tap, or well water?

Any recurring food cravings (such as salt, sugar, carbs, chocolate, etc.):

Lifestyle

Exercise – What type(s) of exercise do you enjoy? How often? (daily/weekly/monthly/etc.)

Self-Care – What does self-care/ritual mean to you? Which self-care rituals do you most enjoy (bath/meditation/socializing/tea/cooking/etc.)? How often are you able to take time for these activities?

Energy Levels

Are you satisfied with your energy levels? 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? What preceded this change?

Do you feel as though your energy levels are affected seasonally?

Systematic Breakdown

We will now look more closely at each of the body's systems for a more detailed assessment. Again, mark all symptoms you are currently experiencing, and feel free to skip over that which does not apply to you.

DIGESTION

Average number of bowel movements per day: _____

___Extreme hunger/cravings
___Lack of appetite
___Emotional eating
___Low blood sugar
___Indigestion
___Heartburn
___Bloated feeling
___Acid reflux
___Gallstones
___Ulcer
___Pain or discomfort in abdomen

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___Nausea
___Gas/Flatulence
___Incontinence
___Diarrhea
___Constipation
___Blood in stool
___Hemorrhoids
___Vomiting
___Anorexia
___Bulimia

RESPIRATORY

Number of colds/flu in the past year: _____

___Hay fever/allergies
___Bronchitis
___Pneumonia
___Cough
___Runny nose
___Thick phlegm
___Shortness of breath
___Asthma
___COPD/Emphysema

CARDIOVASCULAR

___Cold hands and feet
___Spider veins/Varicose veins
___High blood pressure
___Low blood pressure
___Dizziness upon standing
___Tightness in chest
___Palpitations
___Heart murmur
___Bruise easily

HEAD, EYES, EARS, NOSE, AND THROAT

___Poor/blurry vision
___Chronic headache/migraine
___Poor hearing
___Congestion
___Sinus infections
___Ear infections
___Tinnitus/ringing
___Cold/canker sores
___Laryngitis
___Sore throat
___Vocal nodules
___Swollen glands

SKIN AND HAIR

___Dry skin and hair
___Oily skin and hair
___Thinning hair
___Rashes
___Itching
___Eczema
___Psoriasis
___Dandruff
___Acne
___Excessive/night sweating
___Ulcer
___Rosacea

URINARY TRACT/KIDNEY

___Urinary tract infection
___Kidney infection
___Kidney stone
___Painful urination
___Sediment in urine
___Excessive/frequent urination
___Incontinence
___Recent change in flow

MUSCULOSKELETAL

___Muscle pain
___Painful joints
___Joint swelling
___Osteoporosis
___Back pain
___Stiffness
___Muscle weakness
___Muscle strain
___Tendonitis
___Carpal tunnel
___Repetitive Strain Injury (RSI)

NERVOUS SYSTEM

Average hours of sleep per night: _____

Stress level (1-10): _____

___Trouble falling asleep
___Trouble staying asleep
___Insomnia
duration: _____
___Hypersomnia
duration: _____
___Nerve pain
___Headaches
___Shingles
___Anxiety
___Obsessive thinking
___Depression
___Poor memory/concentration
___Numbness or tingling in extremities
___Rapid mood swings
___Impinged nerve
___Poor Self-Confidence
___Body Dysmorphia
___Suicidal thoughts/tendencies
___Addiction(s)
type(s): _____

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FEMALE REPRODUCTIVE

Average length of cycle: _____
Duration of bleeding (days): _____
Birth control (if used): _____
Fertility Medication(s): _____

___Peri-Menopausal
___Post-Menopausal
___Breast lumps
___Pain with intercourse
___Debilitating menstrual pain
___Heavy bleeding
___Irregular bleeding (spotting between cycles)
___Pregnancy
due date: _____
___PCOS
___Endometriosis
___PMS
symptom(s): _____
___Infertility
___Hysterectomy
date: _____
___Miscarriage
date(s): _____
___Abortion
date(s): _____
___IVF
date(s): _____
___Pelvic Inflammatory Disease (PID)
___Chronic UTI
___Foul odor
___Irregular discharge
___Amenorrhea (lack of period for 3mo or more)

MALE REPRODUCTIVE

___Vasectomy
date: _____
___Erectile dysfunction
___Prostate conditions
___Testicle lumps
___Incontinence
___Chronic UTI
___Decreased sperm count
___Other concerns: _____

Family History

Has anyone in your immediate family had any of the following?
Please mark (M) for maternal or (P) for Paternal, and/or list any hereditary conditions to which you may be predisposed.

___Cancer - type(s): _____
___Heart disease
___Diabetes (I / II)
___Other: _____

Injuries

What serious injuries have you had? Have you ever been in an automobile or other serious accident? Have you ever injured your spine or back?

What therapies and/or drugs did you take for them?

Allergies

Do you have any general/seasonal allergies, what are they?

When and where are your allergies least and most troublesome?

Do you have allergic reactions to any prescription drugs or herbal medicines?

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Herbal Preparations

There is a saying amongst herbalists that goes, "the only herbal medicine that works is the one you take." Finding a protocol that you can realistically manage - and stick to - is imperative to your healing journey. Please indicate which preparations you are most willing to work with.

INTERNAL/FOOD PREPARATIONS

___Infusions/teas
___Decoctions
___Alcohol-based tinctures
___Vinegar infusions
___Infused honeys
___Powders
___Herbal broths
___Electuaries
___Syrups
___Hydrosol
___Oxymel (vinegar + honey)
___Flower essences
___Capsules

EXTERNAL PREPARATIONS

___Salves
___Infused oils
___Poultices
___Compress/washes
___Baths/soaks
___Herbal steams
___Aroma therapy
___Hydrosols
___Masks

Would you be willing to set aside time in your day or week to prepare your herbal medicines and foods? Y / N
How much time in a day/week would you like to set aside to prepare your herbal medicines? _____

Additional Comments or concerns:

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