herbal SOLUTIONS 101

Adult Intake Information Form

Name _____ Date _____

Address _____ City _____

Province _____ Postal Code _____

Telephone Number: (Home) _____
(Work) _____
(Cell) _____

Email Address _____

Date of Birth _____ Age _____

Gender: Male ☐ Female ☐

Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐

Occupation _____ Hours per week _____

Retired ☐ Employer _____

Work Address _____

How did you hear about my practice?

_____

Has any other family member been a client at this office? If, so, who?

_____

Emergency contact:

Relationship: Phone #

Address:

Health History Questionnaire

Successful health and preventative medicine are only possible when the herbalist has a complete understanding of the patient physically, mentally and emotionally.

Please complete this questionnaire as thoroughly as possible.

Print all information.

Mark anything you don't understand with a question mark.

General Information

Are you currently receiving healthcare? Yes No

If yes, where?

From whom?

If no, when and where did you last receive medical or health treatment?

What was the reason?

What are your most important health problems? List in order of importance:

1)
2)
3)

4)

5)

Do you have any known contagious diseases at this time? Yes No

If yes, what?

Do you know what your blood type is? Yes No

If so, please identify it: A B O AB

Family History

	Father	Mother	Brother Sister	Brother Sister	Spouse	Child
Age (if living)						
Health (G=Good, P= Poor)						
Age at Death						

Check those applicable:

Cancer						
Diabetes						
Heart Disease						
High Blood pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma						
Hay fever / Hives						
Glaucoma						
Tuberculosis						
Cause of Death						

Illness

For all the following sections please write Y, P or N on the line:

Y= a condition you have now **P**= a condition you have had **N**= never had

Scarlet Fever	Diphtheria	Measles
German Measles	Rheumatic Fever	Mumps

Hospitalizations and Surgery

What hospitalizations or surgeries have you had?

	Date:
	Date:
	Date:
	Date:

X-Rays and Special Studies

X-rays, CAT scans, or other studies that you have had:

	Date:
	Date:
	Date:
	Date:
Electrocardiogram?	Date:
Electroencephalogram?	Date:

Immunizations

Polio?	Pertussis?
Tetanus Shot?	Diphtheria?
Measles?	Other?

Allergies

Are you hypersensitive or allergic to any of the following? If yes, please list them.

Any drugs?

Any environmental?

Other?

Current Medications

Please ✓ if you take or use any of the following:

Laxatives ☐ Pain Relievers ☐ Antacids ☐

Cortisone ☐ Appetite suppressant ☐ Antibiotics ☐

Tranquilizers ☐ Thyroid Medication ☐ Sleeping Pills ☐

Prednisone ☐ Birth Control ☐

Hormone Replacement Therapy ☐

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking.

1)

2)

3)

4)

5)

6)

Typical Food Intake

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Foods you crave:

Foods you dislike:

Foods you are allergic/sensitive to:

General

Height: Weight: Weight one year ago:

Max Weight: When:

When during the day is your energy the best?

The worst?

For all the following sections please write Y, P or N on the line:

Y= a condition you have now **P**= a condition you have had **N**= never had

Mental / Emotional

Treated for emotional problems?		Anxiety?	
Mood Swings?		Tension?	
Considered/Attempted Suicide?		Memory Problems?	
Depression?		Poor concentration?	

Endocrine

Hypothyroid?		Heat or cold intolerance?	
Hypoglycemia?		Diabetes?	
Excessive thirst?		Excessive Hunger?	
Fatigue?		Seasonal Depression?	

Immune

Vaccinations?		Reactions to vaccinations?	
Chronic Fatigue Syndrome?		Chronic infections?	
Chronically swollen glands?		Slow wound healing?	

Neurological

Seizures?		Paralysis?	
Muscle weakness?		Numbness or tingling?	
Loss of memory?		Easily stressed?	
Vertigo or dizziness?		Loss of balance?	

Muscoskeletal

Joint pain or stiffness?		Arthritis?	
Broken bones?		Weakness?	
Muscle spasms or cramps?		Sciatica?	

Blood/Peripheral Vascular

Easy bleeding or bruising?		Anemia?	
Deep leg pain?		Cold hands/feet?	
Varicose Veins?		Thrombophlebitis?	

Skin

Rashes?		Perpetual hair loss?	
Eczema/Hives?		Lumps?	
Night sweats?		Acne/Boils?	
		Color change?	

Head

Headaches?		Head injury?	
Migraines?		Jaw/TMJ problems?	

Eyes

Spots in eyes?		Double vision?	
Impaired vision?		Cataracts?	
Blurriness?		Glasses or contacts?	
Color blindness?		Eye pain/strain?	

Tearing/dryness? ☐ Glaucoma? ☐

Nose and Sinus

Frequent colds? ☐ Nose bleeds? ☐
Stuffiness? ☐ Hay fever? ☐
Sinus Problems? ☐ Loss of smell? ☐

Mouth and Throat

Frequent sore throat? ☐ Copious saliva? ☐
Teeth grinding? ☐ Sore tongue/Lips? ☐
Gum problems? ☐ Hoarseness? ☐
Dental cavities? ☐ Jaw clicks? ☐

Neck

Lumps? ☐ Swollen glands? ☐
Goiter? ☐ Pain/Stiffness? ☐

Respiratory

Cough? ☐ Sputum? ☐
Spitting up blood? ☐ Wheezing? ☐
Asthma? ☐ Bronchitis? ☐
Pneumonia? ☐ Pleurisy? ☐
Emphysema? ☐ Difficulty breathing? ☐
Pain on breathing? ☐ Shortness of breath? ☐
Shortness of breathing at night? ☐ Shortness of breath lying down? ☐

Cardiovascular

Heart disease? ☐ Murmurs? ☐
High blood pressure? ☐ Fainting? ☐
Rheumatic fever? ☐ Low blood pressure? ☐

Swelling in ankles?		Palpitations/Fluttering?	
Angina?		Chest pains?	
clots?		Phlebitis?	

Gastrointestinal

Trouble swallowing?		Hemorrhoids?	
Change in thirst?		Heartburn?	
Nausea?		Change in appetite?	
Vomiting blood?		Vomiting?	
# of Bowel movements per week?		Blood in stool?	
Is this a change?		Pain/Cramps?	
Constipation?		Belching/Gas?	
Diarrhea?		Black stools?	
Gall bladder disease?		Jaundice?	
Ulcer?		Liver disease?	

Urinary

Pain on urination?		Increased frequency?	
Frequency at night?		Inability to hold urine?	
Frequent infections?		Kidney stones?	

Male Reproduction

Hernias?		Testicular masses?	
Testicular pain?		Prostate disease?	
Venereal Disease?		Discharge/Sores?	
Re you sexually active?		Chlamydia?	
Sexual orientation?		Gonorrhea?	
Impotence?		Condyloma?	
Premature ejaculation?		Herpes?	
Syphillis?			
Birth control?		What type?	

Female Reproduction

Age of 1st menses?		Date of last menses?	
Are cycles regular?		Length of cycle?	
Bleeding between cycles?		Duration of menses?	
Painful menses?		Clotting?	
Heavy/excessive flow?		Discharge?	
PMS?		Sexually active?	
PMS Symptoms?			
Birth control?		What type?	
# of Pregnancies?		Number of live births?	
# of miscarriages?		Number of abortions?	
Endometriosis?		Ovarian cysts?	
Difficulty conceiving?		Cervical dysplasia?	
Menopausal symptoms?		Abnormal PAP?	
Pain during intercourse?		Sexual difficulties?	
Chlamydia?		Gonorrhea?	
Herpes?		Condyloma?	
Syphillis?		Do breast exams?	
Sexual orientation?		Breast tender/lumps?	
		Nipple discharge?	

Habits

Main interests and hobbies?

Do you have a religious or spiritual practice? What?

Do you exercise? How often?

What kind of exercise?

Hours of sleep? Enjoy your work?

Sleep well? Wake rested?

Spend time outside?

In a supportive relationship? Have a history of abuse?

Watch television? How many hours?

Read? Any major traumas?

Use recreational drugs? How many hours?

Been treated for drug dependence? When?

Use alcoholic beverages? Treated for alcoholism?

Use tobacco? How many per day?

Drink cola/soda? Drink black/green tea?

Eat refined sugar/artificial sweeteners?

Do you add salt? Crave salt?

How do you heat your home? Gas? Electric? Wood? Water?

How does your condition affect you?

What do you think is happening?

Why?

What do you feel needs to happen for you to get better?

What do you enjoy most about your life?

How much effort are you willing to make at this time to improve your health?

Minimal ☐ Some ☐ Complete ☐

Please write any additional information below:

Welcome!

Please bring in *any and all* medications, vitamins or supplements you are currently taking in their original containers.

Please do not wear any kind of fragrance to your appointment.

If you have any questions, please ask!