Herbal Consultation

CLIENT INTAKE FORM

Name _____ Date _____

Email: _____ Emergency contact _____

Phone _____ Emergency Contact Phone: _____

How did you learn about us? _____

Have you worked with an herbalist before? Yes No

Please list your main concerns/what brings you in today and number in order of significance as well as how long you have had them for:

_____

_____

_____

How do these symptoms inpact your daily life?

_____

_____

_____

What makes these symptoms better/what aggravates your symptoms?

_____

_____

_____

Please list any Perscribed or over the counter pharmaceutical medications that you take and dosage/frequency:

_____

_____

_____

Please list any Herbal medicines, Supplements and Vitamins you currently take:

_____

_____

_____

Do you exercise? Yes No If yes, how many times per week ? _____

What type of movement/exercise to you regularly do? _____

List any Allergies (food, medication or otherwise): _____

List any recent injuries or surgeries: _____

Do you drink Caffeine? If so what form, how much and time of day: _____

Do you Smoke: Yes No No, but did previously. Estimated date range: _____

Do you use Medical Cannabis? Yes No Form: _____

Do you Drink Alcohol? Yes No Frequency/Amount: _____

Menstruation if applicable:

Age when period started: _____

Stage of life, circle one: Menstruating Peri-Menopause or suspected Peri-Menopause Menopause

Please describe any symptoms related to the above. If you are still menstruating please list your general cycle length, number of days menses and any symptoms. You can also list PMS symptoms here as well as menopause symptoms:

_____

_____

_____

List three examples of typical meals for you?
Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

List any go to snacks and drinks:

_____

_____

_____

Do you have daily bowel movements? How many times a day?

_____

Do you regularly experience - Loose stools, Diarrhea, Constipation, Other digestive irregularities? Provide details below:

_____

On a scale of 1-10, 10 being the best, rate the following:

Your Sleep: **Your Stress Levels:**

Your Overall Energy Levels: **Your overall Mood on a daily basis:**

Your Mental Health: **Do you feel you have support of community/family and Friends?**

****Please mark any of the following conditions you may currently have.**

☐ Arthritis	☐ Tinnitus	☐ Epilepsy/Seziures
☐ Frequent headaches	☐ Pelvic Floor Conditions	☐ Insomnia
☐ Sinus Condition	☐ Heart Conditions	☐ Osteoporosis
☐ Infectious Condition	☐ High Blood Pressure	☐ Constipation
☐ Asthma	☐ Low Blood Pressure	☐ IBS
☐ Back Pain	☐ Varicose veins	☐ Migraine's
☐ Joint Swelling	☐ Depression	☐ Problems Focusing
☐ TMJ	☐ Anxiety	☐ Others, please specify
☐ Allergies Seasonal	☐ Diabetes Type_____	_____

Session Consent Statement: I, the undersigned, understand that an herbal consulatation is not a substitute for medical or psychological diagnosis or treatment. It is recommended that I see a licensed physician or health care professional for any physical or psychological ailment I may have. I understand that if I am uncomfortable in any way during my session I have the right to question my practitioner and/or request that the session be terminated, and I will be liable for payment of the scheduled appointment. I affirm that I have answered the above questions to the best of my ability and agree to notify the practitioner if anything changes. I understand that there shall be no liability on the practitioner's part should I fail to do so.

Date of First Visit: _____

First and Last Name _____ **Signature** _____

Practitioner: _____ **Signature** _____