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Client #: _____

Date: _____

Confidential Clinical Intake Record

About this form:

This is a confidential record of your health and wellness history. Information contained herein will not be released to any person unless authorized in writing by you. This information will be used in your consultation for wellness assessment and planning. Please complete this form as thoroughly as possible and return a copy to our office via email or mail prior to your first appointment. If there is a question that makes you uncomfortable, you can leave it blank.

I. Personal Information, Lifestyle, Health Habits & Diet

Legal Name: _____

Preferred Name: _____ Biological Gender: _____ Preferred Gender: _____Birth Date: _____ Age: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact you via the name and mailing address you provided? Yes ___ No ___
Your address will be used to ship herbal extracts and supplements.

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred method of contact: Home Phone: ___ Cell Phone: ___ Email: ___

May we leave a message regarding our call? Yes ___ No ___
If no, please indicate your preferred method of contact: _____

Emergency Contact: (A person we may contact regarding your client record in case of emergency):

Name: _____ Relationship: _____

Contact Phone Number: _____

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Lifestyle & Health Habits

Education: _____ Occupation: _____

For how long? _____ Hours per week? _____ Do you enjoy work? _____

Describe your support system: _____

_____

_____

Are you married, single, partnered, divorced or widowed? _____

Do you smoke? _____ How much per day? _____ If quit, for how long? _____

Do you use hemp (CBD) and or cannabis products? Yes ___ No ___
Please describe which ones and how often including edible / smokable, dose (mg), times per day.

_____

Any past use of addictive or recreational substances? _____

Do you drink alcohol? Yes ___ No ___ Amount per week _____ Types: _____

Are you able to consume herbal supplements or extracts produced with alcohol? Yes ___ No ___

Do you consume caffeine in the form of coffee, tea or soda? Yes ___ No ___
Please indicate which and how often: _____

How often do you exercise and what type? _____

How stressed do you feel of a scale of 1-5 (1= no feelings, 5 = completely stressed): _____

What are the major sources of stress for you? _____

How do you respond to these stressors? _____

How are your energy levels? _____

What time(s) of day is your energy the highest? _____ Lowest? _____

Have your energy levels changed at any point in the recent past and what preceded this change?

_____

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Diet

How would you rate your appetite? Strong ___ Average ___ Weak ___ Almost None ___

List the foods you eat for a typical breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks and times eaten: _____

_____

What foods do you crave? _____

Do you have food allergies? _____

_____

Do you consume any of the following: *Please indicate: S = Sometimes, O = Often, N = Never*

Soy Products ___ Meat ___ Fish ___ Eggs ___ Dairy ___ Poultry ___ Beer ___ Wine ___ Coffee ___

Soda ___ Tea ___ Sugar ___ Candy ___ White bread ___ Whole grain bread ___ Cold cereal ___

Whole grains or quinoa ___ Processed foods ___ Fast food ___ Fried food ___ Restaurant food ___

Raw veggies ___ Cooked veggies ___ Raw fruit ___ Dried or cooked fruit ___ Butter ___

Margarine ___ Canola, soy or corn oil ___ Olive, coconut, or palm oil ___ Organic produce ___

Organic grains ___ Pasture / grass fed eggs, poultry, meat and dairy ___

Do you often: Check all that apply:

Feel rushed during your meals ___ Eat without distractions ___ Eat while standing, reading / TV ___

Eat regular timed meals ___ Over eat ___ Forget to eat ___ Eat until satiated or just under ___

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II. Concerns, Past / Current Health History, Self Evaluation

Present Health Concerns:

Main reason for visit: *(Major complaints, symptoms, concerns)*

_____

_____

_____

How long have you had these conditions? _____

Have any of these concerns or any other aspect of your health recently become worse? Please feel free to use an additional paper if needed for your explanations: _____

_____

Please list all medical diagnosis *(Please include any significant lab results or imaging)*

_____

_____

_____

Medications: In order to evaluate your risk for herb-drug interactions, it is critical that Jody Pesapane is informed of any and all pharmaceutical use. Please list any pharmaceutical medications (both prescribed and over the counter) that you currently take regularly and have taken regularly within the past 6 months. Please include any synthetic or bioidentical hormones (birth control, HRT, Estrogen, Testosterone, Progestogens, GnRH inhibitors). Please continue on a separate piece of paper if necessary.

Current or recent over the counter medications *(e.g. pain relievers, antacids, etc.; include dosage)*

_____

_____

Current or recent vitamins, minerals, herbs, homeopathic, or other supplements: *(Include dosage)*

_____

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_____

_____

1) Medication: _____ 3) Medication: _____
   Dose: _____ Dose: _____
   How often (x per day): _____ How often (x per day): _____
   How long taking it: _____ How long taking it: _____
   Reason for taking it: _____ Reason for taking it: _____
2) Medication: _____ 4) Medication: _____
   Dose: _____ Dose: _____
   How often (x per day): _____ How often (x per day): _____
   How long taking it: _____ How long taking it: _____
   Reason for taking it: _____ Reason for taking it: _____

Please add any additional medications or information about your medications on another sheet if necessary: _____

_____

Do you have any allergies to drugs / pharmaceuticals? Yes ___ No ___
If yes, please list: _____

_____

_____

_____

Previous Illnesses, Hospitalizations, and Surgeries

Date: _____ Diagnosis / Surgery: _____

Date: _____ Diagnosis / Surgery: _____

Date: _____ Diagnosis / Surgery: _____

Date: _____ Diagnosis / Surgery: _____

Current Health Care Provider: _____

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Current Specialists: _____

Current Dietitian / Nutritionist: _____

Current Mental Health Professional: _____

Other Practitioners *(Acupuncturist, massage etc.)* _____

Have you spoken to your current health care team about coming to an herbalist or using herbal supplements? Yes ___ No ___

When was your last physical check up with a doctor? _____

Did your doctor give you special instructions to follow about your health or diet? Yes ___ No ___

If yes, please explain: _____

Do you have recent blood work (within the last 6 months)? Yes ___ No ___
Please attach a copy or email recent bloodwork prior to first appointment.

Family History

	Age	Present illness	Relationship Good? Bad? Okay?
Mother			
Father			
Sisters			
Brothers			

Check illnesses which have occurred in any of your blood relatives:

Diabetes ___ Cancer ___ Allergy ___ Depression ___ Heart disease ___ Stroke ___ Mental health ___

Auto Immune ___ Kidney disease ___ Alcoholism ___ Emotional Abuse ___ Physical Abuse ___

High blood pressure ___ Osteoporosis ___ Other: _____

Self-Evaluation

Please rate the following on a scale of 1-10 (10 being the best)

Sleep: 1___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

Appetite: 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

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Mood: 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

Pain: 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

Relationships: 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

Sex: 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

III. Body Systems

Please rate as 1 = Sometimes 2 = Often 3 = Major Concern or P = Past Condition Leave blank if NA

DIGESTION:

___ Acid reflux	___ Diverticulitis	___ Mouth ulcers
___ Bad breath	___ Flatulence	___ Nausea
___ Bloating	___ Gallstones	___ Parasites
___ Constipation	___ Heartburn	___ Receding gums
___ Crohn's disease	___ Hemorrhoids	___ Stomach ulcer
___ Diarrhea	___ Indigestion	___ Ulcerative colitis
___ Eating Disorder	___ IBS	
___ Forget to Eat	___ Strong appetite, eat regularly	___ Skips meals easily
___ Anxious or faint if skip a meal	___ Get irritable if skip a meal	___ Tired after meal

Other: _____

ELIMINATION:

___ Abdominal pain	___ Loose stool	___ Pale gray stool
___ Blood in stool	___ Food particles in stool	___ Pencil thin stool
___ Mucus in stool	___ Changes in Bowel habits	___ Stool that floats
___ Painful defecation	___ Quick defecation after eating	

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___ Other: _____

How frequently do you have a bowel movement? More than once a day ___ Once a day ___

Once every few days ___ Once a week ___ Other (please explain) _____

Describe the color, shape and size of a typical bowel movement: _____

_____

SLEEP:

___ Circadian rhythm disorders ___ Insomnia ___ Sleep apnea

___ Difficulty falling asleep ___ Narcolepsy ___ Snore

___ Difficulty waking up ___ Parasomnias ___Wake periodically

___ Dreams ___ Restless leg

NERVOUS SYSTEM:

___ ADD/ADHD ___ Insomnia ___ Numbness

___ Anxiety ___ Irritability ___ Obsessiveness

___ Depression ___ Memory loss or changes ___ Overwhelm

___ Headaches / Migraines ___ Mental fog ___ Panic attacks

___ Herpes / Shingles outbreaks ___ Neuralgia ___ Stress

If you get headaches, describe the pain, location and triggers: _____

_____

Which emotions do you experience most frequently? Please use O= Often, S =Sometimes, N=Never

___ Anger ___ Fear ___ Grief ___ Irritability ___ Joy ___ Lethargy

___ Melancholy ___ Restlessness ___ Sadness ___ Worry

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ENDOCRINE / METABOLISM:

___ Burn out
___ Difficulty gaining weight
___ Difficulty losing weight
___ Diabetes
___ Elevated blood sugar
___ Hyperthyroid
___ Hypoglycemia
___ Hypothyroid
___ Metabolic syndrome
___ Pineal
___ Pituitary
___ Other: _____

Other:_____

IMMUNE / LYMPHATIC:

___ Arthritis Rheumatoid
___ Autoimmune disorders
___ Chronic fatigue
___ Frequently sick
___ Injuries heal slowly
___ Low grade fever
___ Low white blood cells
___ Lyme disease
___ Lymphatic congestion
___ Mononucleosis
___ Swollen lymph glands
___ Other: _____

URINARY:

___ Bladder infections
___ Cravings for salt
___ Dark circles under eyes
___ Excessive fear/fearlessness
___ Excessive urination
___ Frequent thirst
___ Frequent urge to urinate
___ Gout
___ Incomplete emptying
___ Incontinence
___ Kidney stones
___ Lower back pain
___ Painful urination
___ Wake up at night to urinate
___ Water retention /edema

Describe the frequency, color and smell of your urine: _____

Other: _____

_____

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SKIN:

___ Acne
___ Bleed or bruise easily
___ Boils
___ Dry / itchy scalp or hair
___ Easily sunburned
___ Eczema and dermatitis
___ Moles
___ Oily, damp scalp or hair
___ Psoriasis
___ Rashes
___ Red, burning or flushed skin
___ Slow wound healing

RESPIRATORY:

___ Allergies / hay fever
___ Asthma
___ Bronchitis
___ Clear, thin mucus
___ Cold
___ Cough
___ Difficulty breathing
___ Dry, hard mucus
___ Easily coughs up mucus
___ Fluid in lungs
___ Pleuritis
___ Postnasal drip
___ Recurrent influenza
___ Runny nose
___ Shortness of breath
___Sinusitis
___ Stuffy nose
___ Tuberculosis
___ Wheezing
___ Yellow / green mucus
___ Other: _____

Other: _____

CARDIOVASCULAR:

___ Atherosclerosis
___ Arteriosclerosis
___ Congestive heart failure
___ Hands cold, clammy or dry
___ Hands warm, sweaty
___ High blood pressure
___ High cholesterol
___ History of heart attack
___ History of stroke
___ Low blood pressure
___ Myocardiopathy
___ Palpitations
___ PFO closure
___ Swelling in ankles/joints
___ Varicose veins

Other: _____

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MUSCULOSKELETAL:

___ Arthritis
___ Backache upper / lower
___ Broken bones
___ Bursitis
___ Carpal tunnel
___ Fibromyalgia
___ Gout
___ Mobility restriction
___ Pain
___ Sprains
___ Stiffness in joints
___ Tendonitis
___ Tennis elbow
___ Torn ligaments

Other: _____

EARS, NOSE, THROAT:

___ Difficulty swallowing
___ Ear aches
___ Ear infections
___ Failing vision
___ Frequent nose bleeds
___ Frequent stuffy nose
___ Hearing loss
___ Laryngitis
___ Sore or bleeding gums
___ Sore throat
___ Tinnitus / ringing in ears
___ Other: _____

Other: _____

REPRODUCTIVE / MEN:

___ Benign prostatic hypertrophy
___ Difficulty with urination
___ Erectile Dysfunction
___ Hernia
___ Impotence
___ Low sex drive
___ Low sperm count /motility
___ Painful ejaculation
___ Prostatitis

Other: _____

Sexually transmitted disease; List types if known: _____

_____

Are you taking synthetic or bioidentical hormones (Estrogen, Testosterone)? Yes ___ No ___

If yes describe with dosage: _____

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REPRODUCTIVE / WOMEN:

___ Absence of menstrual cycles
___ Anemia
___ Bleeding between cycles
___ Breast cancer
___ Clots in menstrual blood
___ Crave sugar before menses
___ Dramatic mood swings
___ Endometriosis
___ Fibroids
___ Genital herpes
___ Heavy bleeding
___ Hysterectomy
___ Infertility
___ Irregular cycles
___ Low libido
___ Menses always lengthy
___ Menses slow to start
___ Ovarian cysts
___ Painful cramps
___ STD's
___ Yeast infections

Please elaborate on inconsistencies or concerns you have about your cycle: _____

_____

Are you pregnant? Yes ___ No ___ Miscarriages? Yes ___ No ___

Number of pregnancies carried to term: _____

Are you taking synthetic or bioidentical hormones (Birth Control, Estrogen, Progesterone, Testosterone, HRT, GnRH inhibitors)? Yes ___ No ___

If yes describe with dosage: _____

MENOPAUSAL WOMEN:

___ Dry vaginal lining
___ Estrogen replacement therapy
___ Hormone replacement therapy
___ Hot flashes
___ Mood swings
___ Night sweats
___ Osteoporosis
___ Sore muscles / joints
___ Other: _____

Other:_____

Please use this space to describe anything else you feel is relevant to your current health concerns:

_____

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