The Herbologist Shop

CLINICAL INTAKE FORM

PERSONAL PROFILE:

Name_____ Phone_____
Email_____Address_____

Where and when have you lived/traveled outside the U.S. or Canada? _____

_____

Date of Birth_____ Age _____ Gender _____ Ancestry/Ethnicity _____

Emergency Contact _____Relationship _____

PRESENT HEALTH CONCERNS:

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

_____

How long have you had these conditions? _____

What was going on in your life in the months preceding this condition? _____

_____

Do you have any symptoms that worsen or improve with: Exertion__Heat __Cold__Pressure__
Please Describe: _____

_____

Do you have a medical diagnosis? (Please include any significant lab results or imaging)

Physician's Treatment: _____

Current or recent prescription medications (dosages and approximate length of time you have used)

_____

_____

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

_____

_____

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Current/recent vitamins, minerals, herbs, homeopathic remedies, or other supplements: (Include dosage) _____

_____

_____

Current or Recent Health Care Practitioners: (Please list names and treatments not yet mentioned)

_____

HEALTH HISTORY:

What other health related issues have you had in the past? (Please describe symptoms and relative dates)

_____

_____

Please list any previous medications and treatments:_____

_____

_____

Please list any operations you have had and the year:_____

_____

_____

Please list any major injuries/accidents, including year:_____

_____

_____

Please list any traumatic experiences not treated medically (divorce, loss of job, death of loved one, etc):

_____

_____

_____

Have you had unusual reactions to any drugs or herbs? _____

_____

Do you have any allergies, sensitivities, or ongoing infections?_____

_____

Known exposure to toxic chemicals, mold, or heavy metals? _____

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FAMILY MEDICAL HISTORY:

	Alive or Deceased?	Age or Age at death	Present illness or cause of death	Briefly describe your relationship
Mother				
Father				
Sisters				
Brothers				

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

____ Diabetes ____ Cancer ____ Allergy ____Anxiety ____ Heart Disease ____ Stroke

____ Bleeding Tendency ____ Kidney Disease ____ Tuberculosis ____Alcoholism

____Emotional Abuse ____ Physical Abuse ____ High Blood Pressure ____Other_____

LIFESTYLE:

Education: _____Occupation _____
For how long? _____ Hours per week? _____Do you enjoy your work? _____
Previous occupation(s) _____
Relationship Status _____ Children? _____
Ages of Children _____ Do you live with: Spouse _____ Partner_____
Parents_____ Child(ren) _____ Friends_____ Relatives_____Alone_____ Pets_____
Do you feel safe?_____ Do you feel appreciated? _____ Do you feel supported? _____
Do you smoke? ____ How much per day? ____ If you used to smoke, when did you quit? ____
What behaviors or habits do you engage in regularly that you believe support your health? __
_____
What behaviors or habits do you engage in regularly that you believe are destructive to your health? _____
_____
Please describe any current or past use of addictive or recreational substances: _____
_____
What kind of exercise do you get on a regular basis? _____
_____
How stressed do you feel on a scale from 1-5 (1 = no feelings of stress; 5 = completely stressed out) _____
What are the major sources of stress for you? _____
How do you respond to these stressors? _____

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ENERGY:

How are your energy levels in general?_____
What time(s) of day are your energy the highest? _____ lowest? _____
Have your energy levels changed markedly at any point in the recent past?_____
If so, what preceded this change? _____

SLEEP:

Do you have any difficulty falling asleep? _____ Staying asleep? _____
What time do you go to bed? _____ What time do you wake up? _____
Do you feel rested?_____ Do you dream? _____
If you wake in the middle of the night, how often do you wake? _____
What times of night do you wake? _____ What wakes you? _____

TEMPERATURE:

Do you run hot or cold? _____
What parts of your body feel the hottest/coldest? _____
What is your favorite temperature/ climate? _____
What part of the day are you warmest and coldest? _____

DIET:

How would you rate your appetite? Strong Average Weak Almost none
List the types of foods you eat for a typical:
Breakfast _____
_____
Lunch_____
_____
Dinner_____
_____
Snacks &Times eaten _____
Fluids_____
What foods do you crave? _____
What are your favorite and least favorite foods and flavors? _____
_____
Do you have any known food allergies? No __ Yes __ List: _____
_____

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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 Foods _____ Eating out at a restaurant

_____ Raw veggies _____ Cooked veggies _____ Raw fruit _____ Dried or cooked fruit

_____Butter _____ Margarine _____ Canola, soy or corn oils _____ Olive, coconut or palm oils

_____ Organic produce and grains _____ Pastured/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, watching TV ____ Eat regularly timed meals _____ Over eat _____ Forget to eat meals ____ Eat until satiated or just under

BODY SYSTEMS please rate as 1= sometimes 2= often 3= major concern or P = past condition. Leave blank if NA

DIGESTION:

____ Acid reflux	____ Diarrhea	____ IBS
____ Anorexia nervosa	____ Diverticulitis	____ Mouth Ulcers
____ Bad breath	____ Duodenal Ulcer	____ Parasites Polyps
____ Bloating	____ Flatulence	____ Polyps
____ Bulemia	____ Gallstones	____ Receding Gums
____ Constipation	____ Hemorrhoids	____ Stomach ulcer
____ Crohn's Disease	____ History of Hepatitis	____ Ulcerative colitis
____ Often 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: please indicate any usual qualities

____ 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	____ Other: _____

How frequently do you have a bowel movement? _____

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Describe the color, shape, & size of a typical BM (I know it's awkward, but it can be very useful information)

_____

URINARY:

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

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

RESPIRATORY:

____ Allergies/Hayfever ____ Difficulty breathing ____Wheezing
____ Asthma ____ Shortness of breath ____ Bronchitis
____ Cough ____ Fluid in lungs ____ Pleuritis
____ Postnasal drip ____ Recurrent influenza ____ Cold
____ Sinusitis ____ Runny nose ____ Tuberculosis
____ Stuffy nose ____ Clear, thin mucus ____ Yellow/Green mucus
____ Dry, hard mucus ____ Easy to cough up mucus ____ Other: _____

CARDIO-VASCULAR:

____ High blood pressure ____ Low Blood Pressure ____ High cholesterol
____ Palpitations ____ Arteriosclerosis ____ Atherosclerosis
____ History of Heart attack ____ History of stoke ____ Congestive Heart Failure
____ Hands cold, clammy or dry ____ Hands warm, sweaty ____ Varicose Veins
____ Swelling in ankles/joints ____ Other: _____

IMMUNE/LYMPHATIC:

____ Arthritis (rheumatism) ____ Autoimmune disorders ____Fibromyalgia
____ Chronic fatigue ____ Neuralgia ____Frequently sick
____ Low-grade fever ____ Low white blood cell count ____ Injuries heal slowly
____ Swollen lymph glands ____ Mononucleosis ____ Lyme disease
____ Lymphatic congestion ____ Feel "unclean" ____ Other: _____

SKIN:

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

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MUSCULOSKELETAL:

____ Arthritis (not rheumatoid)
____ Backache upper/lower
____ Broken bones
____ Stiffness in joints
____ Mobility restriction
____ Broken bones
____ Torn ligaments
____ Bursitis
____ Sprains
____ Tendonitis
____ Gout
____ Other: _____

EARS, NOSE, THROAT:

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

NERVOUS SYSTEM:

____ ADD/ADHD
____ Anxiety
____ Irritability
____ Memory loss or changes
____ Headaches
____ Herpes or shingles outbreaks
____ Depression
____Overwhelm
____ Mental fog
____ Migraines
____ Panic attacks
____Obsessiveness
____ Numbness
____ Stress
____ Insomnia

If you get headaches, can you describe the pain, location & triggers? _____

_____

Which emotions do you experience most frequently? Please use O=often, S=sometimes, N=never

____ Anger ____ Joy ____ Sadness ____ Grief ____ Worry ____ Irritability
____ Fear ____ Melancholy ____ Restlessness ____ Lethargy

ENDOCRINE/METABOLISM:

____ Adrenal fatigue
____ Diabetes (type I or II?)
____ Hyperthyroid
____ Pituitary
____ Hypoglycemia
____ Metabolic Syndrome
____ Difficulty loosing weight.
____ Pineal
____ Elevated Blood Sugar
____ Hypothyroid
____ Difficulty gaining weight
____ Other: _____

REPRODUCTIVE MEN:

Sexually transmitted disease; List type if known: _____

_____

____ Benign prostatic hypertrophy
____ Low sex drive
____ Prostatitis
____ Impotence
____ Low sperm count
____ Difficulty with urination
____ Painful ejaculation
____ Low sperm motility
____ Other: _____

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REPRODUCTIVE WOMEN:

Pregnancies (dates): _____

Miscarriages (dates): _____ Abortions (dates): _____

Contraceptive use: List type and duration of use: _____

_____

Sexually transmitted disease; List type if known: _____

Hysterectomy (date): _____ Reason: _____

____ Uterine Fibroids ____ Ovarian cysts ____ Endometriosis

____ Pelvic inflammatory disease ____ Cervical dysplasia ____ Infertility

____ Vaginal itching/discharge ____ Painful intercourse ____ Vaginal infection

____ Breast pain ____ Fibrocystic breasts ____ Lack of sex drive

MENSTURATING WOMEN:

____ Absence of menstrual cycles ____ Irregular cycles ____Bleeding between cycles

____ Dramatic mood swings ____ Breast tenderness ____ Crave sugar before menses

____ Menses slow to start ____ Menses always lengthy ____Heavy bleeding

____ Painful menstrual cramps ____ Clots in menstrual blood ____ Anemia

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

_____

MENOPAUSAL WOMEN:

____ Dry vaginal lining ____ Hormone replacement therapy ____ Sore muscles

____ Hot flashes ____ Mood swings ____ Night sweats

____ Osteoporosis ____ Estrogen replacement therapy _____ Other: _____

_____

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

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ASSUMPTION OF RISK, RELEASE, COVENANT NOT TO SUE AND AGREEMENT TO HOLD HARMLESS

I hereby accept and assume any and all risk and liability associated with any treatment and/or products provided by The Herbologist Shop, and its agents, owners and/or employees.

I hereby consent to the performance of an evaluation on me (or on the person named below for whom I am legally responsible), which may include but is not limited to pulse and tongue evaluation and the receipt of information regarding herbs, supplements, diet & lifestyle for the purpose of enhancing my health.

I understand that herbal and diet therapy is not intended as a diagnosis, prescription, or treatment for any disease, physical or mental. I further understand that the agents, owners and/or employees of The Herbologist Shop are not licensed to provide any medical treatment or advice.

The herbs and nutritional supplements that may be recommended are traditionally considered safe in the practice of Herbalism; however, it is impossible to predict how an individual may respond to a particular herb. Some possible side effects of taking herbs include but are not limited to nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, and hives. I understand and do not expect the clinical herbalist to be able to anticipate and explain all possible risks and complications of the recommendations.

I understand that recommended herbs are to be consumed or applied as directed, and that I am to immediately stop using them and to notify herbalist of any unanticipated or unpleasant effects associated with the use of herbs.

I understand that some herbs may be inappropriate during pregnancy. I will notify the herbalist if I am or become pregnant. I understand that some herbs may affect medications. I will notify herbalist if I start a new mediation. I understand the results are not guaranteed.

I understand that all my records will be kept secure and confidential in accordance with federal and state guidelines, and that my records and other information will not be disclosed or released without my written consent.

I hereby assume any and all risk of injury to myself and others in my care. I will indemnify and hold harmless The Herbologist Shop and Jody Pesapane from any loss, liability, damage, expense, or cost, whether caused by the herbalist's negligence or otherwise, and whether claimed by or through the undersigned or others, including costs and attorney's fees incurred or suffered by reason of any claims, demands, actions or suits which may be filed or claimed against the herbalist and The Herbologist Shop.

References to the undersigned shall also include and obligate the undersigned's spouse, family, children, guests, invitees, heirs, assigns and agents, and all persons claiming by or through the undersigned. References to herbalist and The Herbologist Shop shall benefit its owners, lessors, officers, employees, agents, successors, and assigns.

_____ _____

Signature Date

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