Herbal and Nutritional Counseling Intake Form

Name:_____**Email:**_____
Address:_____
Phone:_____**Age:**_____**Pronoun:** _____**Gender:**_____
Job/Occupation/How you spend your time:
_____
_____
How many hours per week do you work? _____
What do you do with your free time? _____
Have you received training in healthcare (from weekend workshops to degrees)?
_____
_____
Note: *all information that you provide below will remain confidential unless you ask that it be shared with other providers or loved ones. Please fill it out to your fullest capacity so that I can provide the best care for you.*

Other Health Care Providers (list name and number please, to create a collaborative effort around your health. If you wish that they not be contacted, please say so):
1. _____
2. _____ _____
3._____ _____

1. Constitution. Help me figure out your body type, which will inform me of which herbs may respond best to your body and conditions. For each row, circle what applies to you. If more than one apply, circle more than one.

Body Frame	Thin	Moderate	Abundant
Skin	Rough, dry, dark	Soft, light, moles	Thick, Oily
Appetite	Variable, low	Good, excessive	Slow, steady
Disease tendency	Nervous, pains	Heat, infection	Edema, mucus
Climate Preference	Heat, humidity	Cool, well ventilated	Any climate, no humidity
Sleep	Light, interrupted	Little but sound	Deep, heavy
Elimination	Irregular, constipated	Easy, loose stool	Regular, thick
Work Style	Creative, dislike routine	Love to plan and lead	Methodical, dislike routine

2. Health Background. Please give me a background of your health, from broken bones, to frequent colds, to emotional struggles that noticeably impact your health. Start in infancy, up to the present.
Before AGE 5 _____
_____
_____
Ages 5-10_____
_____
_____
Adolescence_____
_____
Teenage Years_____
_____
Adulthood_____
_____
_____
_____
_____

3. Primary Health Concerns, in the order of priority:

1. _____
2. _____
3. _____
4. _____

4. What do you think is the cause or underlying factor in this health concern?

1. _____
2. _____
3. _____
4. _____

5. Is there anything that helps you feel better with this/these health concern(s)?

1._____
2._____
3._____
4._____

6. Have you received previous diagnoses from other healthcare providers?

_____
_____
_____

7. Please list major events in the last ten years of your life (or further back if it seems significant) and the dates they occurred. Include such events as births, deaths, partnerships, accidents, moves, job changes, miscarriages, trauma or abuse, illnesses, and anything else that has greatly impacted your life.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

8. Do you have any allergies (to food, medication, pollen, etc)?

_____

How do they affect you, and how have you changed your life because of them?

_____
_____
_____

9. Do you take any medications, supplements, or herbs?

Medication/supplement/herb	Dosage/frequency/taking for how long?	for what?	Is it effective? Any side effects?
1.			
2.			
3.			
4.			

10. Sleep and sleep patterns.

What time do you go to bed?_____What time do you rise?_____

How many hours of sleep do you strive for? _____ How many do you actually get? _____

Do you sleep through the night? __Y__N Do you fall asleep easily?__Y__N Do you wake easily? __Y__N

Do you use anything to help yourself sleep? _____
Anything else about how you sleep:
_____
_____

11. Diet and Digestion
What did you eat yesterday?
Breakfast: _____
Lunch_____
Dinner: _____
Snacks: _____
On a day that you are pressed for time, what do you eat?
Breakfast: _____
Lunch_____
Dinner: _____
Snacks: _____
On a day that you have time to take care of yourself, what do you eat?
Breakfast: _____
Lunch_____
Dinner: _____
Snacks: _____
How many cups of coffee do you have per day? _____ How much water do you drink per day? _____
Do you cook for yourself or have homecooked meals prepared by someone else? ___Y____N
How many days per week? _____ How often do you eat in restaurants?_____
Do you have food allergies? __Y__N What are they? _____ _____
Are there foods that you avoid? What are they?
_____
Do you eat sitting down or on the go? _____
Do you eat at consistent times during the day, or just whenever it's available?_____
Do you experience constipation? __Y__N Diarrhea? __Y__N Gas?__Y__N
What seems to be the source of your digestive discomfort?
_____

12. Do you drink alcohol? Do you smoke (anything: cigarettes, marijuana, mullein)? How often, and how much?
_____
_____

13. Do you use other substances? How often, and how much?
_____
_____
_____

14.Menstrual cycle:
____Regular_____Irregular _____Heavy_____Light Length of cycle_____Frequency of Cycle_____
Color of blood: _____
Do you experience: _____cramps_____digestive upset_____acne_____migraines____mood swings
Anything else you'd like to note?
_____
_____
_____

15. Sexual Health. Do you have any pain during sex? What kind? Do you use protection? What kind? Do you, or have you had any sexually transmitted diseases? If so, how have they been addressed?
_____
_____

16. Do you exercise? How much, how often, what kind, and where? How does this make you feel?

_____

_____

17. How are the relationships in your life (friendships, parents, roommates, partners)? Do you believe that these relationships contribute to or challenge your overall wellbeing?

_____

_____

_____

18. Family Health History.

Have any of your family members experienced the following? Please check those that apply.

Allergies/Asthma	Diabetes	High Blood Pressure	Stroke	Tuberculosis
Arthritis	Headaches/Migraines	Kidney Disease	Substance Abuse	UTIs
Cancer-type:	Heart Disease	Liver Disease	Thyroid Disease	

How is the health of your siblings, parents, and grandparents? How have they addressed their health concerns?

Maternal Grandmother:

_____

Maternal Grandfather:

_____

Paternal Grandmother:

_____

Paternal Grandfather:

_____

Mother:

_____

_____

Father:

_____

_____

Siblings:

1. _____
2. _____
3. _____

Thank you! It is my great joy and honor to work with you toward your optimum health. Please give me feedback, as we go along, as to how to work with you better, and feel free to contact me any time.