Client Intake Form and Health Profile

Personal Information

Name_____

Date of Birth _____ Age _____

Address _____Suite/Street_____

City _____ Postal Code _____

Phone number (day) _____ (night) _____

Email address: _____

Employment Status: Full time ___ Part Time ___ Student ___ Retired ___
Unemployed ___ Other ___

Occupation _____
Partner Status _____ Children (#/ages) _____

Note: **The case history notes and medical information recorded during the consultation are kept strictly confidential and will be kept in this office. Information contained here will not be released to any person except when you have authorized me to do so. Please complete this questionnaire as thoroughly as possible.**

What are the major health concerns that brought you here today?
_____
_____
_____
_____
_____

When did this condition begin?
_____

Are you currently receiving care from any other health professional?
(Name) _____

For what condition?
_____

Are you currently using Supplements and Medications? Please continue on a separate page if necessary.

Medication/Supplement/Herb Name	Brand Name	Potency (mg/ iu etc)	Dose Frequency

Do you have any infectious diseases that you know of? Yes ____ No ____
If yes please list

_____
_____

Is there any chance that you are pregnant? Yes ____ No ____

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc)?

_____
_____

Is there any reason you could not take remedies made in alcohol?

_____

Have you had any operations or been in hospital for some other reason? (date and reason)

_____
_____
_____
_____

Accidents/ Injuries (briefly describe)
More than 5 years ago _____
Less then 5 years ago_____

Family Medical History

Please complete this section only for any family members with particular health problems.

	AGE (if deceased, age of death)	HEALTH PROBLEM
Father Mother		
Brothers/ Sisters		
Children		
Other close blood relatives		

Personal Health Habits

Height ____ Current Weight _____Weight 1 year ago _____

Are you a current smoker? _____ How many years?____ Amount per day ? ____
Have you smoked in the past? ____ Do you use recreational drugs? ____
What? _____ Frequency? _____

Are you involved in regular exercise? ____ Frequency? _____
Type? _____ Duration? _____

Diet

Do you drink alcohol? ____ What? ____ Frequency? ____
Do you drink coffee? ____ How much? ____ Tea? ____ How much? ____ Water____
How much? _____

What do you like about your dietary habits and what would you like to change?

_____
_____
_____
_____

Do you now follow or have you ever followed a restricted diet? Please describe and indicate when:

_____
_____
_____
_____

Health Concerns

Please check off if you have experienced any of these in the last 3 months.

Skin and Hair

____ Rashes ____ Eczema ____ Recent moles ____ Poor healing sores
____ Pimples ____ Hives ____ Dandruff ____ Loss of hair
____ Change in skin texture ____ Varicose Veins

Any other noted problems with skin, nails or hair?

_____
_____

Head, Eyes, Ears, Nose and Throat

____ Poor vision ____ Poor hearing ____ Dizziness
____ Blurred vision ____ Ringing in ears ____ Facial pain
____ Spots in front of eyes ____ Earaches ____ Swollen glands
____ Cataracts ____ Sinus congestion ____ Clicking jaw
____ Glaucoma ____ Nosebleeds ____ Canker sores
____ Eye pain ____ Mucous in throat ____ Cold sores
____ Frequent colds ____ Sore throat ____ Grinding teeth

Any other problems with the head?

_____
_____

Cardiovascular

____ High blood pressure ____ Irregular heart beat ____ Easy bruising
____ Varicose veins ____ Low blood pressure ____ Cold hands or feet
____ Chest pain ____ Ankle swelling ____ Blood clots
____ Fainting ____ Palpations. ____ Breathing difficulties

Any other problems with the heart or circulation?

_____
_____

Gastro-Intestinal

____ Nausea ____ Black stools ____ Heartburn ____ Rectal pain
____ Poor appetite ____ Colitis/ IBS ____ Vomiting ____ Bad breath
____Gas ____ Haemorrhoids ____ Gallstones ____ Ulcers
____ Liver problems ____Abdominal pain ____ Food cravings ____ Bloating
____ Diarrhea ____ Indigestion ____ Blood in stools
____ Constipation ____ Mucous in stools ____ Difficulty swallowing

____ # of bowel movements per day
____ Loose ____ Normal ____ Hard?

Stools: ____ float ____ sink ____bad odor ____no odor ____ blood in stool

Do you rely on any of the following for bowel elimination? Yes ___ No ___
Enemas ____ Laxatives ____ Purgatives ____ What type/brand? _____
How often? _____

Any other digestive problems?
_____
_____

Respiratory

____ Cough ____ Bronchitis ____ Pneumonia ____ Pain on breathing
____ Difficulty breathing when lying down ____ Asthma ____ Coughing blood
____ Shortness of breath without exertion
____ Production of phlegm, if yes what color? _____

Any other problems with breathing?
_____

Urinary
____ Pain on urination ____ Urgency of urination ____ Impotency
____ Water retention ____ Frequent urination ____ Kidney stones
____Burning urine ____ Blood in urine ____ Inability to hold urine
____ Irregular flow ____ Decrease in flow
____ Difficulty stopping or starting
____ Interstitial cystitis ____ Prostate enlargement

Any other problems with urination?
_____

Musculoskeletal

____ Neck pain ____ Muscle pain ____ Stiffness ____ Back pain
____ Muscle weakness ____ Broken bones ____ Reduced range of movement

Do you see a Chiropractor or Massage Therapist (name)?
_____

Any other musculoskeletal problems?
_____

Reproductive

____ Age of first period ____ Length of cycle ____ Duration of bleeding
____ Clotting ____ Light Flow ____ Color of Blood
____ Heavy Bleeding ____ Irregular Bleeding ____ Severe menstrual cramps
____ Discharge ____ Color of Discharge ____ Herpes
____ Cervical dysplasia ____ Endometriosis ____ Uterine cysts
____ Fibroids ____ Vaginal itching ____ Anaemia
____ Pelvic inflammatory disease ____ Infertility ____ Hot flashes
____ Dry vaginal lining ____ Osteoperosis ____ Break through bleeding
____ Absence of cycle ____ Pain with intercourse ____ Dramatic mood swings
____ Tubal ligation ____ ERT therapy ____ Mastectomy
____ Hysterectomy ____ Lumpectomy

____ Vaginal infection, If yes what type and for how long?
_____

____ PMS if yes, list symptoms
_____
_____

____ Menopausal Difficulties? List experiences and/or symptoms you are currently experiencing:
_____
_____
_____
_____
_____

Do you have breast implants? ____ Have you noted any problem with these?
_____
_____

Date & result of last PAP
_____

____ # of pregnancies ____ # of births ____ Miscarriages
____ Premature births. ____ Terminations ____ Tubular Pregnancies

Contraceptive History: List the kind(s) if contraceptives you have used, if any, and for how long:
Birth Control Pills_____
____ IUD ____Condoms ____Diaphragm ____Rhythm
____ Mucous method ____Chemical spermicides

Astrological/Other
_____
_____

Any other gynaecological problems?
_____
_____
_____
_____

<u>Neuropsychological</u>

____ Poor sleep ____ Poor memory ____ Numbness ____ Depression
____ Irritability ____ Anxiety ____ Seizures ____ Migraine
____ Headaches ____ High stress levels ____Loss of balance
____ Lack of coordination ____Difficulty concentrating ____ Foggy or spacey feeling

Hours of sleep per 24 hours _____

Any other neurological problems?
_____

Stress management techniques:
_____

<u>General</u>

____ Fatigue ____ Fevers ____ Chills ____ Night sweats
____ Excessive thirst ____ Slow metabolism ____Sudden energy drops
____ Intolerance to heat or cold

Any other health concerns of problems?
_____
_____
_____
_____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins encountered beyond daily life?

_____

_____

Personal

How do you feel about the following areas of your life?

Please check appropriate boxes and make any comments you would like to:

	Excellent	Good	Fair	Poor	Comments
Self					
Work					
Spouse or Significant other					
Sex					
Family					
Personal Goals/ Life Purpose					

Current State of Emotions and Feelings

Please take a moment to answer the following questions:

Are you able to express your feelings and emotions?

_____

Is there an excess of stress in your life?

_____

Do you have tools or techniques to relieve stress?

_____

Are you satisfied with your current environment?

_____

If there is one thing in your life that you would like to change right now, what is it? Can you change it

_____
_____

Are you a ‘nervous type’ person? What are the things, which make you most nervous?
_____
_____

Do you sleep well?
_____

Do you remember your dreams?
_____

What feelings do you most often experience in your life?
Joy, Happiness, Anger, Sadness, Fear, Sympathy, Worry, Depression or _____?

If you were to choose one or two emotions that seem to predominate in your life they would be: _____

Vision Statement

What is your desired goal for your visit?
_____
_____

Ideally what state of health can you visualize achieving for yourself?
_____
_____
_____
_____

Waiver of Liability

I, the undersigned, hereby confirm that I am consulting with Tammy Bergen, Practical Herbalist, of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the above named therapist will offer an assessment of my general health and will make dietary and herbal recommendations. I understand the importance of frequent monitoring to revise the treatment protocol as the symptom picture changes.
Signature _____ Date_____