

Wind Fox Herbal

New Client Intake Form

In order to best naturally support your wellness, it is imperative to have a good understanding of you history. Please take your time and address these questions with as much clarity as possible.

This form will be kept confidential and any information collected cannot and will not be given to anyone outside this clinic without your permission.

Successful client/herbalist relationships are only possible when the practitioner has a full understanding of their client's physical, mental, emotional, and spiritual well being. However, if there are questions that you find difficult to address, or would prefer not to answer, feel free to talk to me about this. Remember your responses will go a long way in assisting my understanding of you, so please take your time in addressing them. Your honesty and attention to detail are greatly appreciated.

Name: _____
Mailing Address: _____
City, State, and Zip code: _____
Phone: _____ Best time to contact you: _____
Email Address: _____
Birthdate: _____
Occupation: _____
Relationship Status: _____

What are your long-term hopes from working with me?

List your major health concerns starting with the ones you feel need the most attention. Also please include the amount of time you have been dealing with this situation as well as the overall severity (from 1 to 10 – 1 being “never noticeable” to 10 being “utterly unbearable”):

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

When did these conditions begin? What were the circumstances surrounding the onset of these conditions? (write on the back of the page if necessary)

List all the medications/drugs you currently take (both prescription and non-prescription) as well as their current dosages:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you sensitive or allergic to anything including vitamins, minerals, prescription drugs, foods, household chemicals, pets, or general environmental substances? Yes No

If yes, please list:

How sensitive would you describe your allergic reactions?

Have you ever had any allergy testing done? What were the findings?

List all vitamins, minerals, herbs, homeopathics, etc ... with dosages:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Practitioners

Are you currently under the care of a health care practitioner? Please note which of the following types of health care practitioners you have seen. Use 'P' if you have seen them in the past and 'C' if you are currently under their care.

___ Acupuncture

___ Psychiatrist

___ Ayurvedic

___ Psychologist

___ Chiropractic

___ Spiritual counselor

___ Counseling

___ Traditional Chinese Medicine

___ Herbalist

___ Medical doctor (type):

___ Homeopath

___ Naturopath

Other (please specify):

___ Massage

___ Physical therapist

How would you describe your overall general health?

Are you happy in your job or career? Yes No

How would you change your job or career if given the choice?

What is your individual and unique purpose in this life?

What behaviors, habits, or thoughts would you like to change?

Do you exercise? Yes No

What form(s)? _____

How often: _____

Do you make time for rest, relaxation, or meditation during the day and/or before bed?

Yes No How often: _____

How do you relax: _____

What are your interests or hobbies: _____

Do you use:

	Now	In the Past	Type	Amount/per week	For how long
Tobacco	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____
Coffee	_____	_____	_____	_____	_____
Cannabis	_____	_____	_____	_____	_____
Recreational Drugs	_____	_____	_____	_____	_____

HEALTH HISTORY:

Please list all major health issues/illnesses/diseases experienced during your lifetime and at what stage of development they happened (write on the back of the page if needed):

Please list any major health issues/illnesses/diseases in your blood relatives:

Mother:

Father:

Siblings:

Grandparents:

Children or Grandchildren:

DIET:

How many meals do you eat each day? One Two Three More than three

Do you: Eat out often Diet frequently Skip meals frequently

Do you have any special diet/eating restrictions? Yes No

If yes, please explain: _____

List the primary foods you include in your diet:

List the foods you exclude from your diet:

Mark which of these you consume regularly Coffee Caffeinated Teas Artificial sweeteners Processed foods Preservatives Refined foods Margarine Fast food Sugar/sweets

List any foods you eat which you suspect may be harmful to your health:

List any foods you crave:

List any foods to which you have a bad reaction:

How much water do you drink daily? _____

What temperature do you prefer to drink? Hot Cold Room temperature

SLEEP:

Do you have trouble falling asleep? Yes No

If yes, what keeps you up? _____

Do you wake at night and have trouble getting back to sleep? Yes No

If yes, what time do you usually wake? _____

In the morning, do you wake feeling refreshed? Yes No

Please explain: _____

Do you have recurring dreams? Yes No

If yes, what is the theme? _____

GENERAL:

In a normal day when do you feel your energy level is at its peak? _____

What time of day is your energy the worst? _____

Please circle which applies best with regards to your overall wellness. Please cross out which option is the worst:

Winter Spring Summer Autumn

Cold Heat

Dampness Dryness

Open Air (being outside) Inside (with windows closed)

Staying put Traveling

Ocean seashore Mountains

Physical exertion Mental exertion

Morning Evening

Other things that make you significantly better or worse: _____

For the following questions, write 'C' for problems you are currently experiencing, 'P' for problems you've experienced in the past, and '?' if you are unsure or have a question.

DIGESTION

Number of bowel movements in an average day _____

- | | |
|--|--|
| <input type="checkbox"/> Extreme hunger/cravings | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Lack of hunger | <input type="checkbox"/> Pain or discomfort in abdomen |
| <input type="checkbox"/> Eat to calm down | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Stomach rumbling |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Gas/Flatulence |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bloating feeling | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Hemorrhoids |

RESPIRATORY

Number of colds/flu in the past year _____

- | | |
|--|--|
| <input type="checkbox"/> Hay fever/allergies | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Thick phlegm |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma |

CARDIOVASCULAR

- | | |
|--|--|
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Dizziness upon standing |
| <input type="checkbox"/> Spider veins | <input type="checkbox"/> Tightness in chest |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Bruise easily |

HEAD, EYES, EARS, NOSE, AND THROAT

- | | |
|---|--|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Sores on mouth |
| <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Chapped lips |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Grind teeth |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Swollen glands |

SKIN AND HAIR

- | | |
|---|---|
| <input type="checkbox"/> Dry skin and hair | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Oily skin and hair | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Night Sweating |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Excessive sweating |

URINARY TRACT

- Urinary tract infections
- Kidney infection
- Kidney stone
- Painful urination

- Sediment in urine
- Frequent urination
- Inability to hold urine
- Recent change in flow

MUSCULOSKELETAL

- Muscle pain
- Painful joints
- Joint swelling
- Weak bones

- Back pain
- Stiffness
- Muscle weakness

NERVOUS SYSTEM

Average hours of sleep a night: _____

- Trouble falling asleep
- Poor quality sleep
- Nerve pain
- Shingles
- Anxiety
- Stress

- Obsessive thinking
- Melancholy/depression
- Headaches
- Poor memory
- Numbness or tingling
- Rapid mood changes

REPRODUCTIVE

Are you currently sexually active? _____

- Sexually transmitted disease
- Feeling excessive sexual drive
- Lack of sexual drive

Male

- Pain on intercourse/ejaculation
- Dribbling urine
- Prostate pain
- Pain/swelling in testicles

- Nocturnal emissions
- Penile discharge
- Difficulty getting an erection

Female

Length of cycle: _____

Duration of bleeding: _____

Last Pap smear: _____

Birth control (if used): _____

- Menstrual pain
- Menopause
- Pain with intercourse
- Heavy bleeding
- Pregnancy

- Miscarriages
- Abortions
- Breast lumps
- Infertility

PMS – Please check all that apply:

- Emotional
- Anxiety
- Cravings
- Bloating/swelling