

# 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?

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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)

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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:

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How sensitive would you describe your allergic reactions?

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

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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?

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Are you happy in your job or career?  Yes  No

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

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What is your individual and unique purpose in this life?

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

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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: \_\_\_\_\_

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**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