CONFIDENTIAL HEALTH AND LIFESTYLE INTAKE FORM

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Dear Patient:
For thoroughness, clarity and to save your valuable time, please complete this form with care. Your answers will help me determine the most effective care for you as quickly as possible. Please print throughout. Any questions that you would rather discuss in person can be marked-off for discussion. I appreciate you taking the time to fill this in prior to our visit. Please bring this completed form with you when you come. Thank you.

PT#:_____

PATIENT INFORMATION

CONSULTATION DATE:_____

NAME:_____ AGE:____ DATE OF BIRTH:_____

ADDRESS:_____ CITY: _____POSTAL CODE_____

PHONE _____ WORK PHONE _____EMERGENCY PHONE _____

MARITAL STATUS: S____ M ____ SEP ____ DIV ____ WID _____ NUMBER OF CHILDREN _____ AGES _____

IF CLIENT IS A CHILD, GIVE THE PARENT'S NAMES: MOTHER _____ FATHER _____

OCCUPATION: _____ HOW LONG:_____

GENERAL INFORMATION

Height _____ weight _____ weight one year ago _____
Do/did you smoke? _____ How long? _____ How many per day? _____
Do you drink alcohol? _____ What kind? _____ How often?_____
Do you drink coffee or tea (caffeinated)? _____ How many per day? _____
Do you use recreational drugs? _____ What kind? _____ How often? _____
Do you exercise regularly? _____how often? _____ What type? _____

What are your hobbies, skills, interests, and/or favourite pastimes?

How would you generally describe your current health?

ALLERGIES OR SENSITIVITIES

DO YOU HAVE ANY ALLERGIES OR SENSITIVITIES? If yes, please list them. Examples: drugs, foods, environmental? Which medicines (including herbal) have you taken for them? When and where are your allergies least and most troublesome? What has most helped your allergies?

MAIN REASON FOR VISIT

WHAT IS THE MAJOR HEALTH CONCERN THAT HAS BROUGHT YOU TO THIS OFFICE?
Please describe all the symptoms in as much detail as possible. Has there been a western medical diagnosis? When did the symptoms first begin? Are they getting worse? What makes it worse or better? How severe are the symptoms? What is the timing, frequency, duration of symptoms? Is there a pattern to the symptoms? What is the relationship between various symptoms? (Please include any significant lab reports):

ARE YOU CURRENTLY ON ANY MEDICATION(S), PRESCRIPTION, TREATMENTS OR OTHERWISE? _____
Example: laxatives, cortisone, pain relievers, tranquillisers, thyroid medication, hypotensive drugs, etc. or other treatments or therapies. if yes, please list them and give dosage. What are the results of the treatment(s):

ARE YOU CURRENTLY TAKING ANY NUTRITIONAL SUPPLEMENTS, VITAMINS, MINERALS OR OTHER HEALTH PRODUCTS? If yes, please list them and the dosage:

ARE YOU CURRENTLY SEEING ANY OTHER HEALTH CARE PROFESSIONALS? YES _____ NO _____
Give the name(s) of health care professional(s) and what they do:

HEALTH HISTORY

PLEASE CHECK ANY OF THE BELOW SYMPTOMS OR DISEASES YOU HAVE EXPERIENCED. Use a scale of 1-5, **1** the least and, **5** being the most severe. If unsure, use a question mark '**?**'.

____AD(H)D	____AIDS	____Alcoholism
____Allergies	____Anaemia	____Anxiety
____Arthritis	____Asthma	____Bloating
____Cancer	____Chemical sensitivities	____Chronic fatigue
____Common cold	____Constipation	____Depression
____Diabetes	____Diarrhoea	____Dizziness
____Drug abuse	____Environmental sensitivities	____Epilepsy
____Epstein-Barr virus	____Excess stress	____Eyesight problems
____Fatigue	____Gynaecological problems	____Headaches
____Hearing problems	____Heart disease	____Hepatitis A, B, or C
____High blood pressure	____HIV	____Hyperglycaemia
____Hypoglycaemia	____Immune disorders	____Injuries
____Low blood pressure	____Male health problems	____Memory loss
____Menopause problems	____Menstrual irregularities	____Numbness
____Painful joints	____Rashes	____Respiratory problems
____Seizures	____Shingles	____Shortness of breath
____Sleep problems	____Sore throats	____Stiffness
____Stomach aches	____Swelling	____Tumours
____Urinary tract infections		

Other:

PREVIOUS MEDICATIONS AND TREATMENTS

HAVE YOU EVER BEEN HOSPITALIZED, HAD ANY OPERATIONS OR ACCIDENTS INCLUDING AUTOMOBILE? Please give the dates and reasons.

HAVE YOU HAD ANY DIAGNOSTIC TESTS OR PROCEDURES OVER THE PAST 2 YEARS? Example: x-rays, cat scans, MRI, blood tests, etc. If yes, please list dates and results.

IMMUNIZATIONS

Please give dates if possible:

polio _____ tetanus / whooping cough / diphtheria _____

flu shot _____ measles / mumps / rubella _____

Other_____

IMMUNE SYSTEM

Please mark '**P**' for previous condition, '**C**' for current and '**?**' if unsure.

____Adenitis	____Allergies	____Autoimmune disorders
____Catch everything	____Chronic fatigue	____Enlarged spleen
____Graves disease	____Hashimoto's thyroiditis	____Heal slowly
____Immunodeficiency	____Infections	____Low grade fever
____Lowered resistance	____Lupus (SLE)	____Mononucleosis
____Myasthenia gravis	____Pernicious anaemia	____Rheumatoid arthritis
____ White blood cell count	_____Sore throats	____Swollen lymph glands

Do you have any concerns about your immune system:

CHILDHOOD ILLNESSES, DISEASES AND SYNDROMES

____Allergies	____Asthma	____Atopic eczema	____Bronchitis
____Chicken pox	____ Ear infections	____German measles (Rubella)	
____Measles	____Mononucleosis	____Mumps	____Rheumatic fever
____Tonsillitis	____Whooping cough (Pertussis)	Other_____	

FAMILY MEDICAL HISTORY

PLEASE NOTE MEDICAL PROBLEMS OF CLOSE FAMILY MEMBERS: (children, sisters, brothers, grandparents, aunts and uncles) For example cancer, diabetes, heart disease, high blood pressure, stroke, epilepsy, mental illness, asthma, hay fever, eczema, anaemia, glaucoma, kidney disease, etc.

Member	Age	Health problem (if deceased, age at death and cause of death)_____
Father	_____	_____
Mother	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENERAL HEALTH

ENERGY LEVELS

Are you satisfied with your energy levels? Please describe:_____

_____

Have your energy levels changed markedly at any point recently or in your past. What preceded this change?

BODY TEMPERATURE

Please write '**H**' for Hot and '**C**' for Cold, if applicable to these body areas:

____General body	____Arms	____Hands
____Palms	____Fingers	____Legs
____Feet	____Genital region	____Head
____Chest	____Stomach	Other_____

Using a scale of **1** (least favourite/strong aversion) to **5** (favourite), check off these weather conditions:

____Hot ____Very hot ____Cold ____Very cold ____Damp ____Dry ____Humid

EMOTIONAL

Use a scale of **1** (rare) to **5** (very common) on the below conditions if they are pertinent to you

____Angry	____Anxious	____Attentive
____Bi-polar	____Depressed	____Dreamy
____Enthusiastic	____Fearful	____Forgetful
____Grumpy	____Happy	____Inspired
____Lethargic	____Manic	____Nervous
____Sad	____Think a lot	____Worry

Other_____

How would you describe your emotional health?

MEMORY AND CONCENTRATION

How is your long-term and short-term memory? Has your memory changed noticeably in the past few years?

How is your concentration? Has it changed? If so, when and in what way?

HEADACHES

Do you ever have headaches? If so, please give as much detail as possible. How often? How long have you had them? Location/type of headaches? What triggers them? Other symptoms associated with the headache (i.e., stomach pain)? Are they more or less often than in the past? Does the severity or intensity vary from episode to episode? What medicines and treatments have you tried, which were most successful?

Please check if the following apply:

____After eating	____Afternoon	____Around eyes
____Around temples	____Aversion to stimuli	____Back of head
____Band around head	____Before eating	____Chronic
____Cluster	____Constant	____Dull
____Evening	____Front of head	____Left side
____Migraine	____Morning	____Night
____Pounding	____Pre-menstrual	____Right side

Other_____

SLEEP PATTERNS

On a scale from **1** (rarely) to **5** (very often) mark the conditions pertinent to you.

____Fall asleep fast	____Sleep through the night
____Hard to fall asleep, but stay asleep	____Hard to fall and stay asleep
____Wake often	____Wake up to urinate
____Restless sleep	____Restful sleep
____Hard to wake up	____Stay awake till 11:00 pm
____Stay awake till 1:00 am	____Stay awake till 3:00 am

Other_____

Which are your favourite hours to sleep?_____

Generally, how many hours of sleep do you need to feel rested?_____

Do you feel rested when you wake in the morning?_____

Dreams (circle those that apply): active, lucid, anxious, nightmares, probing, pleasant, interesting, scary, other_____

REVIEW OF BODY SYSTEMS

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THESE IN LAST 3 MONTHS.

SKIN, HAIR AND NAILS

Mark any of the conditions below that pertain to you. Use '**P**' for past problem and '**C**' for current.

____Acne	____Boils	____Bruise easily
____Dandruff	____Dry hair	____Dry skin
____Eczema/psoriasis	____Hair loss	____Hives
____Impetigo	____Itchy	____Moles changes
____Oily hair	____Oily skin	____Pimples
____Rashes	____Scars	____Sensitive to chemicals
____Skin tags	____Slow to heal	____Texture changes
____Varicose veins	____brittle, cracking nails	____lines, ridges and marks on nails

Any other problems with skin, hair or nails? _____

EYES, EARS, NOSE, MOUTH AND THROAT

Eyes

Have you previously had '**P**' or currently have '**C**'

____do you wear corrective lenses/glasses?	____does the prescription for these change often?
____Glaucoma	____blurred vision
____eye pain	____ cataracts
____spots in front of eyes	Other_____

Date of last eye examination _____

Ears

Have you previously had '**P**' or currently have '**C**'

____Ear infections	____Earaches	____Hearing loss
____Overly sensitive	____Tinnitus/Ringing	____Wax build-up

Other_____

How is your hearing, has it changed in the past years?

Nose, Mouth & Throat

Please list '**P**' for previous or '**C**' for current conditions

____Cavities	____Constant dryness	____Difficultly swallowing
____Excess saliva	____Lip sores	____Loose teeth
____Mouth sores	____Oral herpes/ cold sores	____Painful/tight/clicking jaw
____Sore gums	____Sore throats	____Swollen glands
____Swollen tongue	____mucous in throat	____canker sores
____grinding teeth	____sinus congestion	____changes in sense of smell

Other_____

CARDIO VASCULAR HEALTH

Please check the below questions pertinent to your health:

____Angina	____Arrhythmias (irregular heartbeat)	____Arteriosclerosis
____Black and blue easily	____Bleed easily	____Blood clots
____ Cholesterol issues	____Chest pains	____Congenital deformities
____Congestive heart failure	____Edema	____Fast heart beat (tachycardia)
____Heart flutter	____Heart irregularities	____Heart attack (myocardial infarction)
____Heart murmur	____High blood pressure	____Ischemia
____Low blood pressure	____Mitral valve prolapse	____Palpitation
____Pericarditis	____Poor circulation	____Rheumatic fever
____Slow heart beat (bradycardia)	____Stroke	____Varicose veins
____pins and needles	____swollen ankles and/or hands	____pain/cramping in legs when walking
____ fainting	____ dizziness	____shortness of breath on exertion
____Phlebitis	____ Other_____	

ENDOCRINE SYSTEM

Please check the below questions pertinent to your health:

____thyroid problems	____intolerance to heat or cold	____excessive thirst
____easy weight gain	____hard to gain weight	____light-headedness/dizziness
____irritability/disoriented	____hot flashes	____sweatiness
____sudden energy drops	____symptoms when missed a meal (please list if so):	

MUSCULOSKELETAL

____swollen joints	____muscle pain	____muscle weakness
____neck pain	____back pain	____reduced range of motion
____stiffness	____joint pain	Other_____

Have you had an injury or surgery on bone, muscle, tendon, cartilage or related issue? Do you have any pins or other such items still? If so, when and where?_____

RESPIRATORY

Please mark with a '**P**' for previously a problem, '**C**' for currently so, and '**?**' if unsure.

____Asthma	____Bronchitis	____Chest pain or when breathing
____Common cold	____Coughing	____Difficulty smelling
____Flu (influenza)	____Fluid in lungs	____Hay fever
____Laryngitis	____Pleuritis	____Respiratory inflammation
____Runny nose	____Shortness of breath	____Sneezing
____Stuffy nose	____Tight around lungs	____Trouble breathing in
____Trouble breathing out	____ Wheezing	____Tuberculosis

Other_____

Have you identified foods, environmental factors or situations that worsen your breathing? If so, what are they?

Mucous (check the symptoms which pertain to you) Yes____ No ____

What are the quality and/or color of the mucous:

____Clear	____Green	____Yellow
____Thick/sticky	____Thin/runny	

____Worse in the morning, afternoon, evening, and/or night (circle)

Do you have much congestion? Which season is it worse and best? What helps it?

Cough (check the symptoms which pertain to you) Yes____ No ____

____Bloody	____Dry cough	____Hacking
____Itchy throat	____Painful	____Persistent
____Regularly	____Wet cough	

____Worse at morning, afternoon, evening and/or night (circle)

Do you know of any things that trigger the cough?

URINARY

Please mark '**P**' for previous and '**C**' for current for any of the below conditions or '**?**':

____Bloating	____Blood in urine	____Burning urination
____Frequent urge to urinate	____Kidney/bladder stones	____Kidney pain
____Lower back pain	____Strong smelling urine	____Water retention
____pain when urinating	____inability to hold urine	Other_____

Approximately how many times a day do you urinate?_____

Describe your urine. What colour is it? Is it cloudy or clear? Smell?_____

Do you wake up at night to urinate? If so, how many times?_____

Is it ever difficult to urinate?_____

After urinating, does it ever feel like you still have urine in your bladder?_____

Have you had urinary tract infections? How often? _____

GASTRO-INTESTINAL

Digestion

Please use '**P**' for previously, '**C**' for currently or '**?**' for unsure.

____Anorexia nervosa	____Bulimia	____Changes in bowel habits	____Nausea
____Crohn's disease	____Constipation	____Diverticulitis	____Parasites (i.e. Giardia)
____Dysentery	____Eating disorders	____Flatulence/gas	____Food unappetizing
____Gallstones	____Vomiting	____Heartburn	____Hemorrhoids/rectal pain
____Indigestion	____I.B.S.	____Large appetite	____Liver problems
____Ulcer	____Stomach-aches	____Sudden weight change	____Ulcerative colitis

___ Stomach pains	___ Burping	___ Intolerance to greasy foods
___ Stomach pains after meals	___ Fullness long after meals	___ Headaches after eating
___ Chronic abdominal pain	___ Bloating	___ Sour taste in mouth
___ Sudden, acute indigestion	___ Poor appetite	___ Fatigue and sleepiness after eating
___ Difficulty belching	___ Stomach upsets easily	___ Retain water

___ Abdominal cramps	___ Indigestion 1-3 hrs after eating	___ Seasonal diarrhea
___ Fatigue after eating	___ Lower bowel gas	___ Frequent infections (colds)
___ Alternating constipation & diarrhea	___ Diarrhea	___ Bladder and kidney infections
___ Roughage & fiber cause constipation	___ Stool poorly formed	___ Abdominal cramps
___ 3 or more large bowel movements daily	___ Pain in left side under rib cage	
___ Food allergies	___ Difficulty gaining weight	Other_____
___ Foul-smelling stool		

Bowel Movements (check the symptoms which pertain to you)

____black stools	____mucous in stools	____blood in stools	___white or light grey stools
____floating stools	____sinking stools	____loose stools	___hard stools
____oily film on stools or in toilet bowl	___shiny stools	Other_____	

How many times a day do you have a bowel movement/defecate?_____

Is your need to defecate urgent?_____

DIET - Please fill in the below chart using the following scale:

F –Frequently consume (daily or more) **O**– Occasionally consume (a few times/week)

I – Irregularly consume (less than once/week) **D** – Do not consume this

____Wheat	____Baked goods	____Beef	____Beer
____Black tea	____Bread	____Cheese	____Chicken
____Cigarettes	____Coffee	____Eat out	____Eggs
____Fast food	____Fermented foods	____Fish	____Fried foods
____Fruit	____Grains	____Green tea	____Herbal tea
____Juice	____Milk and milk products	____Nut butters	____Nuts/seeds
____Organic foods	____Pork	____Potato chips	____Refined flour/white flour
____white sugar	____Seafood	____Seaweed	____Sodas/Pop
____Sweets	____Herbal Tea	____Vegetables cooked	____Vegetables raw
____Water	____Wine	Other _____	

Special diets; current and/or previous_____

What are your favourite and least favourite foods?_____

How much do you drink everyday? What do you drink?_____

What did you have for breakfast, lunch and dinner yesterday? (Attached a separate sheet if necessary.)

NERVOUS SYSTEM AND STRESS

Please mark with '**P**' for previously and '**C**' currently to any conditions that are pertinent to you. Please also follow a scale of **1** (noticeable but not a big problem) to **5** (major problem).

____Anxiousness	____Bipolar	____Butterflies in stomach
____Cannot stay asleep	____Constant feeling of stress	____Diminished taste
____Depression	____Fear of facing a new day	____Fluctuating vision
____Hard to concentrate	____Involuntary spasms	____Mania
____Memory loss	____Nervousness	____Numbness
____Pain – constant	____Panic attacks	____Seasonal affective disorder
____Sudden mood swings	____Trouble falling asleep	____Twitching
____Worsening coordination/balance	____low energy	____Seizures
____irritable	____foggy/spacey feeling	Other_____

Describe your stress levels on a scale of '**1**' (not stressed) to '**10**' (really stressed)._____
What goes wrong with your body when stress levels are elevated?

REPRODUCTIVE – MALE AND FEMALE

Have you had any of the following? Write '**P**' for previously '**C**' for currently, '**S**' if you suspect you may have or '**?**' if you have a question about it:

____AIDS	____Candida	____Chlamydia	____Crabs/lice
____Gardnerella	____Genital warts	____Gonorrhea	____HIV
____Syphilis	____STDs	____Trichomonas	____Urethritis

____Human Papilloma Virus (HPV) Other_____

REPRODUCTIVE – MALE

Have you had any of the following symptoms or conditions. Use '**P**' for previously and '**C**' for currently or '**?**' if unsure.

____Benign Prostatic Hyperplasia (BPH)	____Blood in semen	____Blood in urine
____Difficulty getting urine flowing	____Dribbling	____Erectile dysfunction
____Excessive sexual thoughts	____Frequent urination	____Impotence
____Interrupted flow of urine	____Libido low	____ Prostate pain
____Painful ejaculation	____Painful to urinate	____Penis pain
____Testicle pain	____Vitality low	Other_____

Do you get up at night to urinate? If so, how often?_____
Does your prostate region ever hurt? If yes, is pain dull, constant, throbbing or sharp?_____
Is it ever painful to urinate? If so, describe the pain._____
Does the urge to urinate interfere with your daily activities?_____
Do you have any problems getting and/or maintaining an erection?_____
Do you have any health concerns about your sexuality or vitality?

REPRODUCTIVE – FEMALE

Pregnancy

Are you pregnant? If so, how many months?_____
Are you trying to become pregnant? If so, how long have you been trying? _____
Number of pregnancies _____ number of births _____ Premature births _____ miscarriages _____

Use '**P**' for past condition, '**C**' for current, '**S**' for unsure or '**?**' for any questions.

General

____Breast pain	____Cervical dysplasia	____Cysts
____Endometriosis	____Fibroids	____Infertility
____Miscarriage	____Painful intercourse	____Pelvic inflammatory disease (PID)
____STDs	____Tumours	____Unusual PAP
____Vaginal discharge	____Vaginal dryness	____Vaginal infection
_____Vaginitis	Other_____	

Menstrual Cycle

____Acne ____Bleeding between cycles ____Mood swings
____Bloating (hands, stomach) ____Bloating (feet, hands, ankles) ____Irregular cycle
____Painful mensis ____mid cycle discomfort, bloating, pressure
____PMS-if yes, describe symptoms: _____
Age at first period _____ Average number of days bleeding:_____
Approximately how many days between periods? Is it regular or irregular?_____

Menstrual Blood

____Bright red ____Clots ____Dark colour ____Heavy flow
____Profuse flow ____Red ____red brown ____Scanty flow
____Slow flowing ____mucousy ____watery Other_____

Menopause

Are you currently in pre, peri or post menopause?_____ Age when menopause began _____
____Dry vaginal mucosa ____Hormone replacement therapy ____Hot flashes
____Mood swings ____Night sweats ____Osteoporosis
____Sore muscles Other_____

Contraception Method

____Birth control pills ____IUD ____Diaphragm ____temperature/mucous method
Other_____

Are their any other concerns you wish to share?
Please use this space or a separate sheet to write anything else you feel may be important.

STATEMENT OF ACKNOWLEDGEMENT

The health care system in Ontario is under scrutiny. In order to clarify my position as a herbalist, I ask for your co-operation in signing this statement of acknowledgement.

1. That you understand that I am a herbalist not a medical doctor; that I use non-invasive natural methods of assessment and treatment of body dysfunction.
2. That you understand that the methods utilised in this office have a proven clinical foundation, yet may not be accepted practice by standard (allopathic) medicine.
3. That you understand that I reserve the right to determine which cases fall outside of my scope of practice, in which event an appropriate referral will be recommended.
4. That you are accepting or rejecting this care of your own free will.
5. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectations and what I provide are not in agreement.
6. That you understand that fees are payable at the time of the appointment by the patient or guardian. 24 hours notice is required for appointment cancellations; otherwise you will be responsible for the full fee. Any special financial arrangement may be made with me prior to the consultation.

I, _____ have read, understood and acknowledge the above statements.
(Print name)
Signature: _____ Date: _____
(Guardian if applicable)

Please sign and date prior to consultation.