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Client Intake Form

Name _____ Today's Date_____

Address_____

Telephone: work _____home _____best time to call_____

Email _____Do you prefer to be contacted by email? y/n_____

Date of Birth _____Height _____Weight_____

Gender _____ Pronoun used (he, she, they) _____

Married or in long-term relationship? (y/n) ___ # children_____ Ages of children_____

Occupation_____

Emergency contact:_____ Phone:_____

Please describe your current health concerns and/or goals. Rate severity of symptoms on a scale from 1-10. When was the last time you felt truly healthy? What do you feel changed that? (continue on back if necessary)

How does it affect your life?

When did symptoms first appear? Did they coincide with any events? Are they worsening? _____

_____

*What makes it better?*_____

*What makes it worse?*_____

Do you have any formal medical diagnoses? _____
Previous injuries, accidents, illnesses (describe and date) :

_____

_____

*Surgery/Hospitalizations (describe and date)*_____

_____

*What have you tried pharmaceutically or herbally?*_____

_____

*Are you currently taking any medications, herbs or supplements?*_____

_____

_____

*Are you able and willing to make any lifestyle changes at this time?*_____

Can you afford to purchase herbs, herbal preparations, or supplements at this time? We will do our best to fit affordable options into your recommendations. _____

Are you open to educating yourself around your condition and your personal well-being? _____

*Is there anything else important you think is important to mention?*_____

_____

*Describe what a state of well-being would be like for you at this present time in your life:*_____

_____

_____

If you have any blood-work please submit it to consultations@embarkherbals.com prior to, or during, your appointment. Thank-you. We look forward to working with you!

The following continuation of the Health Assessment may or may not apply to you, and you have the option of filling it in (in part, where applicable, or in its entirety, according to your comfort level) and submitting it online prior to your appointment, or bringing it with you the day of your consultation (to in-person appointments). At your discretion, we may review and discuss any applicable key points during your consultation; filling it in ahead of time saves time during consult time. If there is an area you do not feel comfortable filling it, you may leave it blank.

*Please place mark next to any of the following symptoms with **C** that you experience currently or with **P** that you have experienced significantly in the past, and, as needed, 1=occasionally or 2=frequently*

____ Bloating/gas/indigestion	____Heartburn/acid; frequency?	____Constipation
____Diarrhea / loose stools	____# bowel movements day/week	____Abdominal pain
____Mucus/Blood in Stool	____Feel Heavy	____Cysts
____ Skin condition/rash	____Dry skin	____ itching where_____
____Easy/prolonged Bruising	____Thirst Excess	_____Excessive hunger
____Loss of voice	____ Muscle tension / pain	____ Bruise easily
____ Undigested food in stools	____ Sighing	____ Teeth grinding
____ Nausea / motion sickness	____tendon/ligament issues	____Frequent cold / flu
____ Chest pain	____Swelling where_____	____ Asthma / wheezing
____ Heartburn	____ Sinus infections/issues	____frequent colds/flu
____ Hot sensations	____ Cold sensations	____Varicose Veins
____Depression	____ Anxiety	____Defiance
____ Numbness/tingling	____ Bone issues	____Joint pain/inflammation
____ Anger/Short temper	____Irritation/Agitation	____Obsessive thinking
____Heat in chest	____Lack of sex drive	____Low back pain
____Knee pain	____Jaw pain/TMJ/Grinding	____Poor night vision
____Restlessness	____Rib pain	____Easily startled
____ Poor circulation	____ Urinary tract infections	____ Fear / Phobias
____ Eyesight problems	____Light sensitivity	____ Infertility
____Eye floaters /spots	____Dry, red/itchy eyes	____Glasses
____ Earaches/hearing problem	____Ear Ringing (Low)	____Ear Ringing(Hi)
____ Bladder infections	____ Foggy thinking	____Poor memory/word recall
____Premature Gray	____Thinning hair	____Brittle/rigid nails
____ Tight Chest	____Shortness of breath	____Heart palpitations
____Heart Attack	____ Gum disease / bleeding	____Dental problems
____Heart disease	____Blood clots	____Spinal Problems
____Bleeding disorder	____Diabetes	____Osteoporosis
____Low Blood Pressure	____High Blood Pressure	____Stroke
____Hepatitis	____Alcoholism/Drug addiction	____Cancer
____HIV/AIDS	____Allergies	____Asthma
____Appendicitis	____Depression	____Pneumonia
____Serious Fever	____Seizures	____Chicken Pox
____Kidney Disease	____Kidney Stones	____Thyroid Disorder
____Measles	____High Cholesterol	____Liver Disease
____Lyme	____Mono/Epstein Barr	____Blood in urine
____Frequent Urination	____Painful Urination	____Difficult to Pass Urine
____Inability to Hold Urine	____Dark/Pale Urine	____Nighttime Urination

____Urgent Urination ____Difficult to Fall Asleep ____Difficult to Stay Asleep
____Dream Disturbed Sleep ____ # solid hours of sleep/night ____Spasms/Nervous ticks
____Night Sweating ____Daytime sweating ____Absence of sweat
____Speech Difficulty ____Belching/Bloating Headache? ____Weak Muscles
____Ulcers Mouth/Tongue ____Swollen Legs/Feet ____Dizziness ____Cold/Swollen Hands ____Cold Feet ____Fainting
____Hemorrhoids ____Asthma ____Fatigue
____Nosebleeds ____Bleeding Gums ____Color of gums
____Dry Throat/Mouth ____Lump in throat ____Sore throat
____Wet Cough ____Dry cough ____Coughing Blood
____Bronchitis/Pneumonia ____Goiter/Fatty Tumors ____ History of abuse
____Genital herpes ____Genital warts ____Genital Pain
____Painful intercourse ____Sexual dysfunction
____Oral contraceptives
____Genital Rash ____HormoneReplacementTherapy ____Breast lumps/pain/tender
____Headaches Where/Describe_____

WOMEN: *Describe your typical menstruation (if you are menopausal, describe your previous menstrual cycles)_____*
_____
____Clots ____Color of menses ____Length of cycle ____Cramping ____Length of flow ____Vaginal discharge ____Vaginal odor ____Vaginal Dryness ____#Pregnancies ____#Births ____#Miscarriages ____Fibroids/Cysts ____Yeast infections ____#Abortions ____ Age menses began_____
Recent change in menses (describe)_____
____ Menstrual pain/PMS ____ Irregular menstrual cycle, explain_____
____ Menopause related symptoms:_____
_
Any other menstrual issues?_____ Date of last period_____
Could you be, or are you trying, to conceive? _____ Any prior pregnancy/birthing issues_____

MEN: *____Difficulty starting urination ____Stopping and starting urination ____Urinary dribbling ____Urgent urination ____Premature ejaculation ____Difficult to attain/maintain erection*
____Enlarged prostate
Other:_____
_____

LIFESTYLE*: Daily intentional exercise _____*
Describe form and frequency of any other regular physical activity or movement: _____
_____
Does your work/job keep you sedentary or up and moving?_____
Any emotional/spiritual practices (church, yoga, meditation, nature, support groups, aromatherapy)
Do you have any pet/environmental allergies?_____
Food allergies?_____ Chemical sensitivities? _____
Allergies to certain medications?_____
How many hours per night do you sleep?_____ Describe sleep quality_____

*Describe your energy level*_____
*Is it consistently lower at certain times of day? (i.e. morning, afternoon)*_____
*Describe your stress level and causes*_____
_____
*What are the dominant one or two emotions in your life?*_____
_____
*Do you like your work?*_____ *How many hours per week do you work?*_____
*Do you currently smoke tobacco?*_____ *If yes, how many cigarettes/day*_____
*Have you ever smoked in the past?*_____ *For how many years?*_____ *When did you quit?*_____
*Do you currently drink alcohol?*_____ *If yes, type, quantity, and frequency*_____
*Do you smoke marijuana?*_____ *If yes how frequently?* _____
*Use other recreational drugs?*_____ *Past drug use?* _____

Please list any diagnosis or other major or recurring health related events in your life not covered above, including date(s) (continue on back if necessary):

Family Medical History:

Family History: ____Heart disease ____Blood clots ____Cancer ____Diabetes ____High Blood Pressure ____Osteoporosis ____Stroke ____Alcoholism ____Allergies ____Depression ____Anxiety ____ADD/ADHD
*Other:*_____
Please describe any relevant or major health related issues:

*Father*_____

*Mother*_____

*Siblings*_____

*Maternal Grandmother*_____

*Maternal Grandfather*_____

*Paternal Grandmother*_____

*Paternal Grandfather*_____

*Other family members*_____

Medical Providers:

Please list all physicians and other healthcare providers (continue on back if necessary):

Name ***Location*** ***Type of Provider*** ***Date of Last Appt***

1.

2.

3.

4.

5.

6.

Date of last physical exam_____

Results:_____

_____

Blood pressure_____ Cholesterol levels HDL: _____ LDL:_____ Triglycerides:_____

Please attach any bloodwork or other relevant paperwork you have.

Dietary Information: You may attach a 3 day diet log if desired

Low Appetite ____Heavy Appetite ____Meat ____Vegetarian ____Vegan ____
Intense Thirst? ____Prefer Hot Beverages ____Prefer Cold Beverages ____
Daily water consumption (# glasses/day)_____Daily coffee consumption (# cups/day)_____
Other beverages (list amounts)_____
Intense hunger?____ Crave Sweets ____Crave Salt_____
List any recurring food cravings_____

Please describe your typical meals. Be as specific as possible; for example, instead of "vegetables" describe type and amount of vegetable; instead of "oil" describe type and amount of oil; instead of "bread" describe type and amount of bread (whole grain, white, etc.). Include any beverages such as coffee, tea, herbal teas, juice, etc.

Breakfast_____

morning snacks_____

Lunch_____

afternoon snacks_____

Dinner_____

evening snacks_____

Supplements and Medications:

List all herbs, vitamins, and dietary supplements you take regularly or were taking until recently, citing brand name whenever possible (use additional space on back if necessary). You can scan & attach labels if easier.

Product	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

List all medications you take regularly or were taking until recently both prescription (P) and over the counter (OTC) - use additional space on back if necessary. You can scan & attach labels if easier.

Product	P/OTC	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			

6.

7.

8.

9.

10.

History of antibiotic use? (list frequency)_____