

Free Clinic Intake Form

(For Office Use Only)

Herbalist: _____

Client Last Name #: _____

Case Number: _____ Date: _____

PERSONAL INFORMATION

Name (First & Last): _____

Address (for shipping herbal formulas to): _____

Phone: _____ Email: _____

Birthdate: _____ Age (as of today): _____

Height: _____ ft, _____ inches Weight: _____ lbs. Gender/Gender Identity: _____

HEALTH ASSESSMENT

What is the main reason for your visit today? _____

Are there any other health issues you would like to address today? _____

How would you rate your overall health on a scale of 1-10 (1=poor, 10=excellent)? *Check one*

1	2	3	4	5	6	7	8	9	10
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How would you rate your overall outlook on life on a scale of 1-10 (1=negative, 10=positive)?

1	2	3	4	5	6	7	8	9	10
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How would you rate your overall stress level on a scale of 1-10 (1=no stress, 10=extremely stressed)?

1	2	3	4	5	6	7	8	9	10
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SEVERE SYMPTOMS

Are you experiencing any of the following symptoms? *(Check all that apply)*

<input type="checkbox"/>	Severe pain	<input type="checkbox"/>	Numbness, tingling, or paralysis	<input type="checkbox"/>	Lumps, swellings, sore lymph nodes
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Sudden severe headache	<input type="checkbox"/>	Depression with thoughts of suicide
<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Blood in the urine	<input type="checkbox"/>	Persistent or severe fatigue
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Sudden rash with fever	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	Unusual shortness of breath	<input type="checkbox"/>	Severe stomach pain	<input type="checkbox"/>	Black tarry stool
<input type="checkbox"/>	Chest pain/tightness in chest	<input type="checkbox"/>	Recent fainting or loss of consciousness	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	Bleeding of any kind	<input type="checkbox"/>	Visual disturbances, visual loss	<input type="checkbox"/>	

HEALTH INFORMATION

Do you have any diagnosed medical conditions? ___ No ___ Yes If yes please list: _____

Are you allergic to any medications or herbs? ___ No ___ Yes If yes, please list: _____

Are you allergic to any foods? ___ No ___ Yes If yes, please list which foods & the severity of the allergic reaction: _____

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Do you use tobacco or nicotine products? No Yes If yes: times per day times/week
 Never Ex-smoker? How long ago? _____ Ex-vaper? How long ago? _____

Do you consume alcohol? No Yes If yes: times/day times/week times/month
 never Are you a recovering alcoholic? No Yes If yes, how long sober? _____

Do you use cannabis? No Yes If yes, check ones you use: Smoking Vaping oils CBD
 Edibles ; times/day times/week times/month Ex-user? How long ago? _____

How often do you drink coffee/caffeine? times/day times/week times/month never

How often do you drink soft drinks? times/day times/week times/month never

How often do you drink energy drinks? times/day times/week times/month never

Do you have any other addictions or habits? No Yes If you want to share more: _____

Have you experienced a major trauma in any way? (physical, emotional, and/or mental) No Yes

If you want to share more: _____

How often do you exercise? minutes per day days per week never

On average, how many hours of sleep do you get? weekdays _____ weekends _____

Is your sleep disturbed? No Yes If yes, how? _____

PRESCRIPTIONS, HERBS, VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDICATIONS

Please list all that you are taking.

Name of Medication/Herb/Supplement	Dose <i>ie: 500 mg, 1 tsp, etc.</i>	Frequency taken <i>1/day, 3/day, 1/week, as needed, etc.</i>	Prescribed (RX) or Self Care (SC)