ACORN School of Herbal Medicine

(For Office Use Only)

Herbalist: _____

Client Last Name #: _____

Case Number: _____ Date: _____

Free Clinic Intake Form

PERSONAL INFORMATION

Name (First & Last): _____

Phone: _____ Email: _____

Birthdate: _____ Age (as of today): _____

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

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, using an X*

	1		2		3		4		5		6		7		8		9		10

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

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

SEVERE SYMPTOMS

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

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

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:

_____

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? _____

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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** *ie: 500 mg, 1 tsp, etc.*	**Frequency taken** *1/day, 3/day, 1/week, as needed, etc.*	**Prescribed (RX) or Self Care (SC)**