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)