**New Client Intake Form**

**Please Note**. This detailed intake form has many questions that may or may not pertain to your condition. These questions are searching for potentially undiagnosed conditions and connections between ailments. Please feel free to answer only those questions you feel are important towards your current health concerns; or to finish the entire form.

You don’t have to write down anything if you don’t want to – we will ask if there’s something important we need to know. Everything is completely confidential and will only be seen by **Hilltop Herbals** health consultants. Any questions that you would rather discuss in person can be marked-off for future discussion. If you need more room to answer any questions, use the back of the form.

Name Today’s date

Address \_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height Weight\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Preferred pronoun(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activities, occupation, skills, interests, hobbies, or favorite pastimes:

**Main reason for visit** (symptoms, diagnoses, main complaints, whatever you want advice about)

Other health issues:

Are you sensitive to any medications?

Have you been diagnosed with anything? Do you agree with the diagnosis?

Current medications and treatments:

Could you possibly be pregnant?

Are you currently breastfeeding?

**Exercise**: What type of daily, weekly or monthly exercise do you practice?

**Drug History**

Please list any drugs, prescription or otherwise, you are using.

(We won’t use this information for anything other than determining potential herb-drug interactions. All information is confidential. Feel free to ask us about harm reduction information and supplies.)

**Health History**

Please check any of the below symptoms or diseases you have experienced. You can mark with a ‘**P**’ (past), ‘**C’** (current), or ‘**?**’ if you are unsure.

\_\_\_\_AD(H)D

\_\_\_\_AIDS

\_\_\_\_Alcoholism

\_\_\_\_Allergies

\_\_\_\_Anemia

\_\_\_\_Anxiety

\_\_\_\_Arthritis

\_\_\_\_Asthma

\_\_\_\_Bloating

\_\_\_\_Cancer

\_\_\_\_Candida

\_\_\_\_Chemical sensitivities

\_\_\_\_Chronic fatigue

\_\_\_\_Common cold

\_\_\_\_Constipation

\_\_\_\_Diabetes

\_\_\_\_Diarrhea

\_\_\_\_Dizziness

\_\_\_\_Environmental sensitivities

\_\_\_\_Epilepsy

\_\_\_\_Epstein-Barr virus (mononucleosis)

\_\_\_\_Excess stress

\_\_\_\_Eyesight problems

\_\_\_\_Fatigue

\_\_\_\_Fibromyalgia

\_\_\_\_Headaches

\_\_\_\_Hearing problems

\_\_\_\_Heart disease

\_\_\_\_Hepatitis A

\_\_\_\_Hepatitis B

\_\_\_\_Hepatitis C

\_\_\_\_High blood pressure

\_\_\_\_HIV

\_\_\_\_Hyperglycemia

\_\_\_\_Hypoglycemia

\_\_\_\_Immune disorders

\_\_\_\_Injuries

\_\_\_\_Irritable Bowel Syndrome

\_\_\_\_Low blood pressure

\_\_\_\_Lyme disease

\_\_\_\_Memory loss

\_\_\_\_Menopause problems

\_\_\_\_Menstrual irregularities

\_\_\_\_Multiple Sclerosis

\_\_\_\_Numbness

\_\_\_\_Painful joints

\_\_\_\_Rashes

\_\_\_\_Respiratory problems

\_\_\_\_Seizures

\_\_\_\_Sexual health issues

\_\_\_\_Shingles

\_\_\_\_Shortness of breath

\_\_\_\_Sleep problems

\_\_\_\_Sore throats

\_\_\_\_Stiffness

\_\_\_\_Staph Infections

\_\_\_\_Stomach aches

\_\_\_\_Swelling

\_\_\_\_Tumors

\_\_\_\_Urinary tract infections

\_\_\_\_Yeast infections

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to toxins(lead paint, construction work, pesticides, etc.)

**Immune System**

Use ‘**P**’ for previous condition, ‘**C**’ for current, or ‘**?**’ if unsure.

\_\_\_\_Adenitis

\_\_\_\_Allergies

\_\_\_\_Autoimmune disorders

\_\_\_\_Catch everything

\_\_\_\_Celiac

\_\_\_\_Chronic fatigue

\_\_\_\_Cushing’s disease

\_\_\_\_Enlarged spleen

\_\_\_\_Graves disease

\_\_\_\_Hashimoto’s Thyroiditis

\_\_\_\_Heal slowly

\_\_\_\_Immunodeficiency

\_\_\_\_Infections

\_\_\_\_Low grade fever

\_\_\_\_Lowered resistance

\_\_\_\_Lupus (SLE)

\_\_\_\_Mononucleosis

\_\_\_\_Myasthenia gravis

\_\_\_\_Pernicious anemia

\_\_\_\_Rheumatoid arthritis

\_\_\_\_\_Sick often

\_\_\_\_\_Sore throats

\_\_\_\_Swollen lymph glands

\_\_\_\_\_White blood cell count

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about your immune system?

**Energy levels**

Are you satisfied with your energy levels? Please describe.

When are the high and low points of your daily energy levels?

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

**Family History**

Has anyone in your immediate family had any of the following?

\_\_\_\_Cancer

\_\_\_\_Heart disease

\_\_\_\_High blood pressure

\_\_\_\_Low blood pressure

\_\_\_\_\_\_Diabetes

Other\_\_\_\_\_\_\_\_\_\_

**Childhood History**

Were you breastfed? How long?

Were you regularly vaccinated as a child?

Please list any recent vaccines:

Please briefly describe your birth story, if known:

**Allergies**

Do you have any allergies? What are they?

What are your reactions?

Which medicines (including herbal) have you taken for them?

When and where are your allergies least and most troublesome?

Do you have allergic reactions to any drugs or herbal medicines?

What has most helped your allergies?

**Diet**

Please fill in the below chart using the following scale:

**F** –Frequently consume (daily or more)

**O**– Occasionally consume (a few times a week)

**I** – Irregularly consume (generally less than once a week)

**D** – Do not consume this

\_\_\_Alcohol

\_\_\_Black tea

\_\_\_Cigarettes

\_\_\_Coffee

\_\_\_Eat out

\_\_\_Fast food

\_\_\_Refined flour

\_\_\_Refined sugar

\_\_\_Soda

\_\_\_Soy

\_\_\_Sweets or sugar

\_\_\_Fried foods

\_\_\_Dairy

\_\_\_Fermented foods

\_\_\_Meat

\_\_\_Fish

\_\_\_Fruit

\_\_\_Nuts/seeds

\_\_\_Organic foods

\_\_\_Vegetables (raw) \_\_\_Vegetables (cooked)

\_\_\_Water

Other\_\_\_\_\_\_\_\_\_\_\_\_\_

What oils do you eat/cook with?

Special diets (current and/or previous):

What did you have for breakfast, lunch and dinner yesterday?

How much water did you drink yesterday?

**Digestion**

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

\_\_\_\_Anorexia nervosa

\_\_\_\_Belching

\_\_\_\_Bulimia

\_\_\_\_Changes in bowel habits

\_\_\_\_Crohn’s disease

\_\_\_\_Constipation

\_\_\_\_Diarrhea

\_\_\_\_Diverticulitis

\_\_\_\_Dysentery

\_\_\_\_Eating disorders

\_\_\_\_Flatulence

\_\_\_\_Food unappetizing

\_\_\_\_Gallstones

\_\_\_\_Giardia

\_\_\_\_Heartburn

\_\_\_\_Hemorrhoids

\_\_\_\_Indigestion

\_\_\_\_Irritable bowel syndrome

\_\_\_\_Large appetite

\_\_\_\_Liver problems

\_\_\_\_Low appetite

\_\_\_\_Nausea

\_\_\_\_Pain after eating

\_\_\_\_Parasites

\_\_\_\_Shigella

\_\_\_\_Stomach aches

\_\_\_\_Sudden weight change

\_\_\_\_Ulcer

\_\_\_\_Ulcerative colitis

\_\_\_\_Vomiting

**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 favorite) to **5** (favorite), please check off these weather conditions:

\_\_\_\_Hot

\_\_\_\_Very hot

\_\_\_\_Cold

\_\_\_\_Very cold

\_\_\_\_Damp

\_\_\_\_Dry

\_\_\_\_Humid

**Emotional**

Please describe your emotional or mental health. If you want, use three words (or more).

**Ears**

Use ‘**P**’ for past condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Ear infections

\_\_\_\_Earaches

\_\_\_\_Hearing loss

\_\_\_\_Overly sensitive

\_\_\_\_Tinnitus/Ringing

\_\_\_\_Wax build-up

Other\_\_\_\_\_\_\_\_\_\_\_\_

**Mouth & Throat**

Use ‘**P**’ for past condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Canker sores

\_\_\_\_Cavities

\_\_\_\_Constant dryness

\_\_\_\_Difficulty swallowing

\_\_\_\_Excess saliva

\_\_\_\_Excess mucous

\_\_\_\_Lip sores

\_\_\_\_Loose teeth

\_\_\_\_Mouth sores

\_\_\_\_Oral herpes

\_\_\_\_Painful/tight jaw

\_\_\_\_Receding gums

\_\_\_\_Sinus problems

\_\_\_\_Sore gums

\_\_\_\_Sore throats

\_\_\_\_Swollen glands

\_\_\_\_Swollen tongue

\_\_\_\_White coating on tongue

Other\_\_\_\_\_\_\_\_\_\_\_\_

**Headaches**

Do you ever have headaches? How often? How long have you had them?

Location and 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?

What medicines and treatments have you tried, and which were most successful?

**Urinary Tract**

Use ‘**P**’ for past condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Bloating

\_\_\_\_Blood in urine

\_\_\_\_Burning urination

\_\_\_\_Frequent urge to urinate

\_\_\_\_Kidney/bladder stones

\_\_\_\_Kidney pain

\_\_\_\_Lower back pain

\_\_\_\_Strong smelling urine

\_\_\_\_Urinary tract infections

\_\_\_\_Water retention

Other\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how many times a day do you urinate?

Do you wake up at night to urinate? 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? How did you treat them?

**Bowel Movements**

How many times a day do you defecate?

Is it ever difficult to defecate? Do you strain to defecate?

Do your feces tend toward loose (soft) or hard?

Are you ever constipated? How often?

Do you ever have diarrhea (very loose stools)?

Is your need to defecate urgent?

Does it ever hurt to defecate?

Other bowel problems or symptoms:

**Sexual and Reproductive System Health**

Have you had any of the following? Use ‘**P**’ for past condition, ‘**C**’ for current, , ‘**S**’ if you suspect it and ‘**?**’ if you’re unsure or have any questions.

\_\_\_\_AIDS

\_\_\_\_Candida

\_\_\_\_Chlamydia

\_\_\_\_Crabs/lice

\_\_\_\_Gardnerella

\_\_\_\_Genital warts

\_\_\_\_Gonorrhea

\_\_\_\_Herpes (I or II)

\_\_\_\_HIV

\_\_\_\_Human Papilloma Virus (HPV)

\_\_\_\_Syphilis

\_\_\_\_Trichomonas

\_\_\_\_Urethritis

Other\_\_\_\_\_\_\_\_\_\_

Please list any herbs or drugs you have used as treatment for the above.

Have you had any of the following symptoms or conditions? Use ‘**P**’ for past condition, ‘**C**’ for current, or ‘**?**’ if unsure.

\_\_\_\_Bacterial vaginosis

\_\_\_\_Benign Prostatic

Hyperplasia (BPH)

\_\_\_\_Blood in semen

\_\_\_\_Blood in urine

\_\_\_\_Breast pain

\_\_\_\_Cervical dysplasia

\_\_\_\_Cysts

\_\_\_\_Difficulty getting urine flowing

\_\_\_\_Dribbling

\_\_\_\_Endometriosis

\_\_\_\_Erectile dysfunction

\_\_\_\_Fibroids

\_\_\_\_Frequent urination

\_\_\_\_Impotence

\_\_\_\_Infertility

\_\_\_\_Interrupted flow of urine

\_\_\_\_Miscarriage

\_\_\_\_Painful ejaculation

\_\_\_\_Painful intercourse

\_\_\_\_Painful to urinate

\_\_\_\_Pelvic inflammatory disease (PID)

\_\_\_\_Penis pain

\_\_\_\_Prostate pain

\_\_\_\_Testicle pain

\_\_\_\_Tumors

\_\_\_\_Unusual PAP

\_\_\_\_Vaginal discharge

\_\_\_\_Vaginal dryness

\_\_\_\_Vaginal infection

\_\_\_\_Vaginitis

Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about emotional health related to your hormonal cycles?

Are you currently taking any form of hormones?

Do you use any form of contraception? If so, what kind?

Does your prostate region ever hurt? If yes, is pain dull, constant, throbbing or sharp?

**Pregnancies Dates:**

Number of miscarriages:

Number of abortions:

Children:

Please briefly describe the birth(s) of your child(ren):

Do you have any health concerns about your sexuality?

**Menstrual Cycle**

\_\_\_\_Acne or skin changes

\_\_\_\_Bleeding between cycles

\_\_\_\_Bloating

\_\_\_\_Painful menses (how is it painful?)

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average number of days bleeding: \_\_\_\_\_

Approximately how many days are there between your menses? Are they regular or irregular?

Do you have any concerns about emotional health related to your menstrual cycles?

**Menstrual Blood**

\_\_\_\_Bright red

\_\_\_\_Clots

\_\_\_\_Dark colored

\_\_\_\_Heavy flow

\_\_\_\_Scanty flow

\_\_\_\_Slow flowing

Other\_\_\_\_\_\_\_\_\_\_

**Menopause**

Are you currently in pre, peri or post menopause?

\_\_\_\_Dry vaginal mucosa

\_\_\_\_Hormone replacement therapy

\_\_\_\_Hot flashes

\_\_\_\_Mood swings

\_\_\_\_Night sweats

\_\_\_\_Osteoporosis

\_\_\_\_Sore muscles

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 easy to stay asleep

\_\_\_\_Hard to fall asleep or remain asleep

\_\_\_\_Wake often. What hours?

\_\_\_\_Wake up to urinate

\_\_\_\_Restless sleep

\_\_\_\_Restful sleep

\_\_\_\_Hard to wake up

\_\_\_\_Sleepless nights

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which are your favorite 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?

**Cardiovascular Health**

Use ‘**P**’ for past condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Angina

\_\_\_\_Arrhythmias (irregular heartbeat)

\_\_\_\_Arteriosclerosis

\_\_\_\_Bruise easily

\_\_\_\_Bleed easily

\_\_\_\_Capillary fragility

\_\_\_\_Cardiac arrest

\_\_\_\_Chest pains

\_\_\_\_Congenital deformities

\_\_\_\_Congestive heart failure

\_\_\_\_Edema

\_\_\_\_Fast heart beat (tachycardia)

\_\_\_\_Heart attack (myocardial infarction)

\_\_\_\_Heart flutter

\_\_\_\_Heart irregularities

\_\_\_\_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

Other\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular Health, continued**

Resting pulse rate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood pressure (average) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cholesterol (if know, LDL, HDL and total cholesterol):

Blood type, if known:

Do you usually run colder or hotter than people around you?

**Nervous System and Stress**

Use ‘**P**’ for previous condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure. Please also follow a scale of **1** (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

\_\_\_\_Dramatic seasonal emotional changes

\_\_\_\_Sudden mood swings

\_\_\_\_Trouble falling asleep

\_\_\_\_Twitching

\_\_\_\_Worsening coordination

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your stress levels. What happens with your body when stress levels are elevated?

**Respiratory**

Use ‘**P**’ for previous condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Asthma

\_\_\_\_Bronchitis

\_\_\_\_Chest pain

\_\_\_\_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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Mucous**: quality and/or color

\_\_\_\_Clear

\_\_\_\_Green

\_\_\_\_Yellow

\_\_\_\_Thick/sticky

\_\_\_\_Thin/runny

\_\_\_\_Worse in the morning, afternoon, evening, night (circle)

Have you identified foods, environmental factors or situations that worsen your breathing?

What are they?

**Cough:** Check the symptoms which pertain to you.

\_\_\_\_Bloody

\_\_\_\_Dry cough

\_\_\_\_Hacking

\_\_\_\_Itchy throat

\_\_\_\_Painful

\_\_\_\_Persistent

\_\_\_\_Regularly

\_\_\_\_Wet cough

\_\_\_\_Worse at morning, afternoon, evening, night (circle)

\_\_\_\_Triggers

Are there any other concerns you wish to share?