AutumnTide
Herbal Wellness

Health History Intake Form

Please answer the following as best as you are able and return it to the herbalist prior to your appointment

Name:_____ Gender: _____ Preferred Pronoun: _____
Address:_____City:_____State:_____Zip:_____
Date of birth: _____ Height _____ Weight_____
Phone Numbers: Home_____ Cell_____
Email Address: _____
How did you hear about our clinic?_____

Reason for today's visit - Primary Concern(s):

When did you first notice this problem?

What if anything makes it better?

What makes it worse?

How is the pain on a scale of 0-10 (0=no pain, 10=worst pain)?

Have you had a Medical evaluation?

Secondary health concern(s):

Have you been treated for any of the above with conventional medicine, herbs, acupuncture or any other modality? Please describe:

Past Medical History

Have you ever been diagnosed with any of the conditions listed here? When? Describe any treatments.

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Hepatitis ☐ Thyroid disease ☐ Seizures ☐ Other?

Surgeries (including cosmetic & dental)? Provide date for each. _____

Hospitalizations? Provide date and reason for each. _____

Allergic to drugs/chemicals/foods? How were they diagnosed and/or treated? _____

Major trauma (concussion, accidents, physical or emotional trauma)? Provide date for each. _____

List of all medications or supplements you have used in the past 6 months.

_____

_____

Family Medical History

Has anyone in your immediate, biological family (parents, grandparents, siblings or children) ever been diagnosed with any of these conditions?

☐ Cancer/Type _____ ☐ Diabetes ☐ Heart disease ☐ High Blood Pressure

☐ Thyroid Disease ☐ Mental Health Issues ☐ Seizures ☐ Alcoholism ☐ Hepatitis

☐ Other (please list) _____

Lifestyle

Do you tend to feel hot or cold generally? _____ Do you prefer hot or cold climates? _____

Do you sweat easily or often? _____

What emotion do you feel most often? _____

Whom do you live with? _____ Relationship status? _____

Do you enjoy your home life? _____ Do you enjoy your social life? _____

Occupation: _____ How long have you had this occupation? _____

Describe your job/work. _____

How many hours per day? _____ Hours worked per week? _____ Paid Vacation/Sick Time? _____

Commute time to and from work: _____

Do you enjoy your work? _____

Exercise type and frequency:

How long have you been involved in this type of exercise? _____

Sleep Habits

	Hours of sleep per night		Dreams
	Different sleep schedule on weekends/days off		Use sleep medications. How often?
	Work at night		Sleep apnea
	Insomnia		Wake during the night. Usual Time?
	Trouble falling asleep		Night Sweats
	Trouble staying asleep		

General Habits

Cigarettes: Do you currently smoke? _____How many cigarettes per day? _____

If you smoked in the past, for how many years did you smoke? _____

When did you quit? _____

How much water do you drink each day? _____

Coffee: How many cups per day? _____

Tea: What kind? _____ How much per day? _____

Soda: What kind?_____ How many sodas per day? _____

Alcohol: How much alcohol do you drink each day? _____Each week? _____ Each month? _____

What kind of alcoholic beverages do you enjoy? _____

Has your drinking ever caused problems in your life such as family issues, job loss, legal problems?

Recreational drugs: Are you currently using any kind of recreational drug? _____
What kind and how often? _____ Have you used them in the past? _____

Have you ever been treated for drug or alcohol addiction? _____
Are you currently in any type of recovery program? _____

Do you take prescription medications for depression, anxiety or other psychological symptoms?

Diet

Please provide a brief idea of your typical diet:

Breakfast:

Lunch:

Dinner:

Snacks/Desserts:

Do you prefer your food/drinks to be hot or cold: _____

How long have been at your current weight? _____ Any significant weight gain/loss in the past five years?_____

Have you ever been treated for an eating disorder? _____

☐ Good appetite? ☐ Poor appetite?

Do you crave specific foods or flavors? _____ Which ones? _____

Health History

Please check any health issue that you have had in the past or are currently experiencing.

Skin

	Rashes (where?)		Acne
	Ulcerations		Excessively oily skin
	Hives		Excessively dry skin
	Itching		Hair loss
	Eczema		Dandruff
	Psoriasis		Other

Eyes, Ears, Nose, Throat

	Glasses or contacts		Frequent ear infections
	Glaucoma or Cataracts		Hearing loss
	Migraine or other chronic headaches		TMJ
	Night blindness		Chronic dental problems (cavity/root canal/etc)
	Ringing in ears		Cold Sores
	Sinus problems (chronic congestion/infections)		Mouth ulcers
	Blurred Vision		Gum disease
	Red/Itchy Eyes		Dry Mouth
	Seasonal Allergies		Other

Cardiovascular

	High or low blood pressure		Fainting
	Elevated cholesterol or triglyceride levels		Swelling in hands or feet/legs
	Poor circulation		Chest pain
	Heart disease		Pacemaker
	Heart palpitations		Blood Clots
	Heart Disease		Other

Respiratory

	Chronic cough		Frequent Bronchitis
	Allergies		Frequent Pneumonia
	Frequent colds/respiratory infections		Emphysema
	Asthma (onset/treatment)		Number of colds/sinus infections per year
	Difficulty breathing		Lung disease (describe)
	Breathless with exertion		Other

Urinary Tract

	Bladder infections (current or in the past)		Wake up in the night to urinate
	Cystitis		Blood in urine
	Kidney infections		Incontinence
	Kidney stones		Frequent urination
	Family history of kidney disease		Other

Gastrointestinal

	Number of bowel movements per day		Gastric reflux
	Nausea		Heartburn
	Gas		Irritable Bowel Syndrome
	Belching		Bloating after meals
	Indigestion		Crone's disease
	Bad breath (halitosis)		Undigested food in stool
	Constipation		Hemorrhoids
	Diarrhea		Blood or Mucus in stool
	Alternating Constipation and Diarrhea		Other

Men: Reproductive Health

	Prostate inflammation or swelling		Pain or difficulty urinating
	Prostate cancer		Sexually transmitted disease/type?
	Infertility issues		Low Libido
	Impotence or erectile problems		Other

If you are over 50 years of age: Do you have annual PSA screening? Last screening:

Women: General Reproductive Health

	Age of first menses		Ovarian cysts/PCOD
	Length of period		Fibroids/type?
	PMS		Sexually transmitted disease/type?
	Heavy menstrual flow		Uterine or Ovarian cancer
	Blood clots		Pelvic inflammatory disease
	Irregular menstrual cycle		Breast lumps/cysts
	Skipped periods		Breast cancer
	Breakthrough bleeding		Low Libido
	Painful periods		Other

Date of last PAP: Date of last mammogram:

Pregnancy

	Have you ever been pregnant?		Health issues during pregnancy?
	Are you or could you be pregnant now?		Currently using birth control
	Number of live births		Type of birth control used:
	Number of miscarriages		Infertility issues
	Number of abortions		Other

Date of last PAP: Date of last mammogram:

Peri-menopausal/Menopausal symptoms (please check all that apply)

	Are you currently having regular menstrual periods?		Headaches
	Hot flashes		Heavy menstrual bleeding/flooding
	Hot flashes during AM or PM?		Incontinence/frequent urination
	Night sweats		Memory problems/Poor concentration
	Insomnia/sleep problems		Mood swings
	Weight gain		Depression
	Low libido		Fatigue
	Vaginal dryness		Currently using bio-identical hormones
	Currently using hormone replacement therapy		Other

Date of last menstrual period:

Musculoskeletal

	Chronic neck or back pain		Low back pain
	Neck or shoulder tightness		Rheumatoid arthritis
	Osteoarthritis		Frequent sprains/torn ligaments
	Osteoporosis		Limited Range of Motion
	Muscle Cramping/ Spasms		Joint Pain/Instability
	Muscle Atrophy/Weakness		Other

Neuropsychological

	Depression		Frequently feel overwhelmed
	Anxiety attacks		Experiencing high stress levels
	Poor memory		Ever considered or attempted suicide
	Difficulty concentrating		Treated for depression or psychological issues
	Lose your temper easily		Treated for alcohol or drug addiction
	Startle Easily		Abuse Survivor
	Worry Frequently		Other

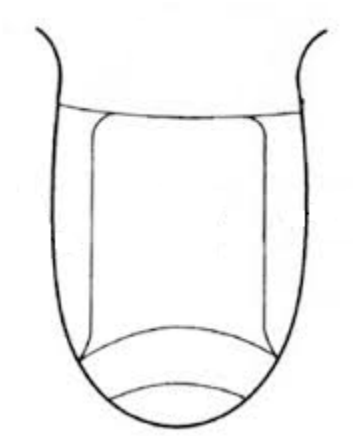
Neurological

	Fainting/Lightheadedness		Seizures/Epilepsy
	Stroke/CVA/TIA		Vertigo
	Dizziness		Numbness
	Loss of Balance		Paralysis
	Tremors		Other

How would you rate your stress level right now?

Is there anything else affecting your health right now that you would like me to know about?

Tongue:



Pulses:

Left

1 -

2 -

3 -

Right

1 -

2 -

3 -

Herbal Assessment:

Treatment Principle:

Herbal Treatment:

Dietary recommendations

Lifestyle Recommendations