Katolen Yardley, MNIMH, Medical Herbalist
Clinic Intake Form and Health Profile

Personal Information

Name_____

Date of Birth _____ Age _____

Address

Suite/Street _____ City _____ Postal Code _____

Phone number (day) _____ (night) _____

Email address: _____ Do you wish to receive our online Health Newsletter? Yes / No

Do you wish to be informed of our periodic vacation and out-of-office dates by email, in order to ensure you will not run out of product during this time and can schedule your follow up appointments ? Yes / No

Employment Status: Full time ___ Part Time ___ Student ___ Retired ___ Unemployed ___ Other ___

Occupation _____ Partner Status _____ Children (#/ages) _____

Do you have extended medical coverage? Provider _____ Policy Number _____

Note: The case history notes and medical information recorded during the consultation are kept strictly confidential and will be kept in this office. Information contained here will not be released to any person except when you have authorized me to do so. Please complete this questionnaire as thoroughly as possible.

Where did you hear about my clinic? _____

What are the major health concerns that brought you here today? _____

_____

_____

_____

When did this condition begin?_____

Are you currently receiving care from any other health professional? (Name) _____

For what condition? _____

Are you currently using Supplements and Medications? Please continue on a separate page if necessary.

Medication/Supplement/Herb Name	**Brand Name**	**Potency (mg/ iu etc)**	**Dose**	**Frequency**

_____

_____

Do you have any infectious diseases that you know of? Yes ____ No ____ If yes please list _____

Is there any chance that you are pregnant? Yes ____ No ____

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc)? _____

_____

Is there any reason you could not take remedies made in alcohol? _____

Have you had any operations or been in hospital for some other reason? (date and reason) _____

_____

_____

Accidents/ Injuries (briefly describe)
More than 5 years ago _____

Less then 5 years ago _____

Family Medical History

Please complete this section only for any family members with particular health problems.

	AGE (if deceased, age of death)	HEALTH PROBLEM
Father		
Mother		
Brothers/ Sisters		
Children		
Other close blood relatives		

Personal Health Habits

Height ____ Current Weight _____Weight 1 year ago _____

Are you a current smoker? _____ How many years?____ Amount per day ? ____ Have you smoked in the past? ____
Do you use recreational drugs? ____ What? _____ Frequency? ____

Are you involved in regular exercise? ____ Frequency? _____ Type? _____
Duration? _____

Diet

Do you drink alcohol? ____ What? ____ Frequency? ____
Do you drink coffee? ____ How much? ____ Tea? ____ How much? ____ Water____ How much? _____
What do you like about your dietary habits and what would you like to change?_____

_____

_____

Do you now follow or have you ever followed a restricted diet? Please describe and indicate when: _____

_____

_____

Health Concerns

Please check off if you have experienced any of these in the last 3 months.

Skin and Hair

____ Rashes ____ Poor healing sores ____ Hives ____ Itching
____ Eczema ____ Pimples ____ Dandruff ____ Loss of hair
____ Recent moles ____ Change in skin texture ____ Varicose veins

Any other noted problems with skin, nails or hair? _____

Head, Eyes, Ears, Nose and Throat

____ Poor vision ____ Cataracts ____ Glaucoma ____ Earaches
____ Blurred vision ____ Poor hearing ____ Ringing in ears ____ Sore throat
____ Canker sores ____ Cold sores ____ Grinding teeth ____ Nosebleeds
____ Facial pain ____ Clicking jaw ____ Eye pain ____ Sinus congestion
____ Mucous in throat ____ Dizziness ____ Frequent colds ____ Spots in front of eyes
____ Swollen glands

Any other problems with the head? _____

_____

Cardiovascular

____ High blood pressure ____ Low blood pressure ____ Chest pain ____ Fainting
____Irregular heart beat ____ Cold hands or feet ____ Ankle swelling ____ Palpations
____ Easy bruising ____ Varicose veins ____ Blood clots ____ Breathing difficulties

Any other problems with the heart or circulation? _____

_____What is your blood pressure? _____

Gastro-Intestinal

____ Nausea ____ Vomiting ____ Diarrhea ____ Constipation
____ Black stools ____ Bad breath ____ Indigestion ____Abdominal pain
____ Heartburn ____Gas ____ Blood in stools ____ Mucous in stools
____ Rectal pain ____ Haemorrhoids ____ Bloating ____ Food cravings
____ Poor appetite ____ Gallstones ____ Ulcers ____ Difficulty swallowing
____ Colitis/ IBS ____ Liver problems

____ # of bowel movements per day
____ Loose ____ Normal ____ Hard?
Stools: ____ float ____ sink ____bad odor ____no odor ____ blood in stool
Do you rely on any of the following for bowel elimination? Yes ___ No ___ How ofter? ___
____ Enemas ____ Laxatives ____ Purgatives ____ What type/brand? _____

Any other digestive problems? _____

Respiratory

____ Cough ____ Bronchitis ____ Asthma ____ Coughing blood
____ Pneumonia ____ Pain on breathing ____ Shortness of breath without exertion
____ Difficulty breathing when lying down ____ Production of phlegm, if yes what color? _____

Any other problems with breathing? _____

Urinary

____ Pain on urination ____ Frequent urination ____ Blood in urine
____ Urgency of urination ____ Kidney stones ____ Irregular flow
____ Impotency ____ Inability to hold urine ____ Decrease in flow
____ Water retention ____ Burning urine ____ Difficulty stopping or starting
____ Prostate enlargement ____ Interstitial cystitis

Any other problems with urination? _____

Musculoskeletal

____ Neck pain ____ Muscle pain ____ Stiffness ____ Back pain
____ Muscle weakness ____ Broken bones ____ Reduced range of movement

Do you see a Chiropractor or Massage Therapist (name)?_____

Any other musculoskeletal problems? _____

Reproductive

____ Age of first period ____ Length of cycle ____ Duration of bleeding ____ Clotting
____ Light Flow ____ Color of Blood ____ Heavy Bleeding ___ Irregular Bleeding
____ Severe menstrual cramps ____ Discharge ____ Color of Discharge ____ Herpes
____ Cervical dysplasia ____ Endometriosis ____ Uterine cysts ____ Fibroids
____ Vaginal itching ____ Anaemia ____ Pelvic inflammatory disease ____ Infertility
____ Hot flashes ____ Dry vaginal lining ____ Osteoperosis ____ ERT therapy
____ Break through bleeding ____ Dramatic mood swings ____ Absence of cycle ____ Hysterectomy
____ Pain with intercourse ____ Tubal ligation ____ Mastectomy ____ Lumpectomy

____ Vaginal infection, If yes what type and for who long? _____

____ PMS if yes, list symptoms _____

_____

____ Menopausal Difficulties? List experiences and/or symptoms you are currently experiencing: _____

_____

Do you have breast implants? ____ Have you noted any problem with these? _____

Date & result of last PAP _____

____ # of pregnancies ____ # of births ____ Miscarriages ____ Premature births
____ Terminations ____ Tubular Pregnancies

Contraceptive History: List the kind(s) if contraceptives you have used, if any, and for how long:

Birth Control pills _____
____ IUD ____Condoms ____Diaphragm ____Rhythm ____ Mucous method ____Chemical spermicides

Astrological/Other _____
Any other gynaecological problems? _____

_____

Neuropsychological

____ Poor sleep ____ Poor memory ____ Numbness ____ Depression
____ Irritability ____ Anxiety ____ Seizures ____ Migraine
____ Headaches ____ High stress levels ____Loss of balance ____ Lack of coordination
____Difficulty concentrating ____ Foggy or spacey feeling

Hours of sleep per 24 hours _____
Any other neurological problems? _____
Stress management techniques: _____

General

____ Fatigue ____ Fevers ____ Chills ____ Night sweats
____ Excessive thirst ____ Slow metabolism ____Sudden energy drops ____ Intolerance to heat or cold

Any other health concerns of problems? _____
To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins encountered beyond daily life? _____

Personal

How do you feel about the following areas of your life? Please check appropriate boxes and make any comments you would like to

	EXCELLENT	GOOD	FAIR	POOR	COMMENTS
Self					
Work					
Spouse or significant other					
Sex					
Family					
Personal Goals/ Life Purpose					

Current State of Emotions and Feelings

Please take a moment to answer the following questions:

Are you able to express your feelings and emotions? _____

Is there an excess of stress in your life? _____

Do you have tools or techniques to relieve stress?_____

Are you satisfied with your current environment?_____ _____

If there is one thing in your life that you would like to change right now, what is it? Can you change it? _____

_____

Are you a 'nervous type' person? What are the things, which make you most nervous? _____

_____

Do you sleep well? _____

Do you remember your dreams? _____

What feelings do you most often experience in your life? joy, happiness, anger, sadness, fear, sympathy, worry, depression or _____?

If you were to choose one or two emotions that seem to predominate in your life they would be: _____

Vision Statement

What is your desired goal for your clinic visit?_____

_____

Ideally what state of health can you visualize achieving for yourself?

_____

_____

Waiver of Liability

I, the undersigned, hereby confirm that I am consulting with Katolen Yardley, MNIMH, Medical Herbalist, of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the above named therapist will offer an assessment of my general health and will make dietary and herbal recommendations. I understand the importance of frequent monitoring to revise the treatment protocol as the symptom picture changes.

Signature _____ Date _____