CLIENT INTAKE

Let's Get Started

WELLNESS

HERBAL MEDICINE AND REIKI TREATMENTS

Name:

Age & Date of Birth:

Preferred Name:

Email address:

City of Residence:

Phone Number:

Occupation & Hours Worked Weekly:

Share a Home with:

Height:

Weight:

Please list reasons for today's visit (your chief health concerns):

Are you currently seeing any other practitioners for these concerns? (ie: Medical Doctor, Chiropractor, Naturopath, Massage, Acupuncture, etc)

CLIENT INTAKE

KMC WELLNESS
HERBAL MEDICINE AND REIKI TREATMENTS

Please list any medications you are on and what for what condition:

Please list any allergies:

How many hours of sleep do you get each night?

Briefly describe your level of physical activity (types and frequency):

What would you describe as the two dominant emotions in your life right now?

Who are the most important people in your life right now?

CLIENT INTAKE CONT.

KMC WELLNESS
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For the following, please indicate the frequency of weekly use:

Coffee
Tobacco Products
Alcohol
Aspirin/Ibuprofen/Acetaminophen
Weed Products
Laxatives
Other Drugs:

Please indicate which symptoms you have had in the Past (PT) or Present (P):

HIgh Blood Pressure
Autoimmune Condition
Low Blood Pressure
Arthritis / Joint Pain
Drug Abuse
Urinary Tract Infections
Yeast Infections
Mononucleosis
Lymphedema / Edema
Mumps / Measles
Diabetes
Alcohol Abuse
Gas / Bloating
Hyperglycemia / Hypoglycemia
Digestive Issues
Constipation / Diarrhea
Asthma / Allergies
Growths / Benign Tumors
Eating Disorders
Frequent Coughs
Heartburn / Ulcers
Chronic Fatigue
Eczema / Psoriasis
Cardiac Issues
HSV / Shingles
Cancer - Type:
Memory Loss
Trauma
Headaches / Migraines
Other:

Please list any hospitalizations, surgeries, or major injuries:

Please list any major events in the past 10 years of your life that have significantly impacted you and the dates they occurred (this could include job change, marriage, divorce, accidents, moves, miscarriages, illness, births, deaths, or anything else that may have impacted your life):

CLIENT INTAKE CONT.

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Men

Do you experience any of the following; past (PT) present (P)

Pain in testes	STDs
Benign Prostate Hypertrophy (BPH)	Prostate Pain
Lowered Sexual Desire	Blood in Urine or Semen
Dribbling	Frequent Urination
Impotence / Erectile Dysfunction	Other:

Women

Do you experience any of the following; past (PT) present (P)

Lowered Sexual Desire	Infertility
STDs	Vaginal Dryness
Miscarriage	Abortion
Unusual PAP	Endometriosis
Fibroids	Ovarian cysts
Polycystic Ovarian Syndrome	Painful Intercourse
Other:	Date of last pelvic exam:
Are you on birth control - type:	

Menstruation and Menopause symptoms

Hot Flashes	Pain / Cramps
Amenorrhea / Irregular Periods	Irritability
Bloating	Brown Blood / Clotting
Cravings	Acne
Breast Tenderness	Other:

Have you ever taken antibiotics? If so, when?

CLIENT INTAKE CONT.

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How often do you have a bowel movement (once/twice daily, every other day, etc.)

From the Bristol Stool Chart, what would you say your bowel movements closely resemble (you may have to Google the chart):

How much time do you spend each day on the phone or on the computer? Are you up on your feet and active or sedentary at work?

How much water do you drink daily?

How often do you get outside? When during the day is this?

CLIENT INTAKE CONT.

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Are you currently on any specialized diet?

Have you had any recent testing such as blood work, imaging, stool tests, or other medical testing?

Any additional comments for your Herbalist: