

THE POSSIBLE CANINE

Herbal Consultation for Humans Client Intake Form

INTAKE FORM

Name

Height and weight:

Height: _____ Weight: _____

Address

Occupation:

Gender

Male Female

Hobbies and special interests:

Date of birth

Physical activities you engage in:

Please list all medications, including herbs and vitamins you are presently taking, or therapies you are presently undergoing:

Have you ever undergone herbal therapy before?

Yes: No:

Do you generally respond well to medical treatments, medicines, therapies, etc.?

Yes: No:

Please list any known allergies or sensitivities to any medication, herb or natural supplement, or food.

A. PRIMARY COMPLAINT -- (Describe your symptoms to the best of your ability):

B. SECONDARY COMPLAINTS --- (List any other symptoms you are experiencing regardless of whether it seems related to your primary complaint):

When did you first notice it?

A _____ B _____

How long has it been occurring?

A _____ B _____

When and under what circumstances does it seem to improve?

A _____ B _____

Have you been treated by anyone else for this condition?

A _____ B _____

If so, when and by whom?

Medical History (List all past illnesses, injuries and operations):

Blood Type?

Ancestry? (What part of the world your parents/grandparents lived):

Indicate if you have experienced any of the following conditions: If you have in the past, use a P, if recently use an R, if frequently also include an F.

HBP

P: R: F:

LBP

P: R: F:

Heart problems

P: R: F:

Shortness of breath

P: R: F:

Asthma

P: R: F:

Hypoglycemia

P: R: F:

Epilepsy

P: R: F:

Nervous Complaints

P: R: F:

Spasms/twitches

P: R: F:

Bloat:

P: R: F:

Low Body Temp.

P: R: F:

Gallstones

P: R: F:

Kidney Stones

P: R: F:

Hepatitis

P: R: F:

Specify type & dates:

Carcinoma

P: R: F:

Specify location

Allergies:
P: R: F:

Sinus infections
P: R: F:

Headaches:
P: R: F:

Frequent colds & flu:
P: R: F:

Poor memory:
P: R: F:

Cold Hands and Feet
P: R: F:

Undigested food in stools:
P: R: F:

Loose stools:
P: R: F:

TB
P: R: F:

Anemia:
P: R: F:

Diabetes:
P: R: F:

Disability of back:
P: R: F:

Other (specify):

Sleepiness after meals:
P: R: F:

Enlarged lymph nodes:
P: R: F:

Enlarged spleen:
P: R: F:

Enlarged liver:
P: R: F:

Mononucleosis:
P: R: F:

Hearing Difficulties
P: R: F:

Constipation:
P: R: F:

Depression:
P: R: F:

Over-excitable:
P: R: F:

Diarrhea:
P: R: F:

Tight neck/shoulders:
P: R: F:

Disability of knees:
P: R: F:

Cancer
P: R: F:
(specify location and type)

Low back pain:
P: R: F:

Frequent urination:
P: R: F:

Nighttime urination:
P: R: F:

Dental problems:
P: R: F:

Thyroid Problems
P: R: F:
Specify:

Eyesight difficulties:
P: R: F:

Glandular problems
P: R: F:
Specify:

Mood Swings:
P: R: F:

PMS:
P: R: F:

Disability of hips
P: R: F:

Disability of ankles:
P: R: F:

How would you describe your energy level? High Low Up and down

Do you get gas and/or bloat? Yes: No:

How would you describe your elimination?

Bowel Movements: Are they regular (daily): Yes: No:

Urine: Is your urinary frequency more than 6x/day or less than 4x/day?

More: Less: Color _____

Do you experience nighttime urination? Yes: No:

Number of times/night?

Once

How would you describe your sleep?

Any recurring dreams?

How is your memory?

How would you describe the stress level in your life?

Home _____

Work _____

Other _____

Do you have an unusual susceptibility to heat or cold?

What temperature do you prefer in terms of climate and foods?

Do you use alcohol, cigarettes, cola, sugar coffee, marijuana, cocaine or any other recreational drug? (specify frequency and quantity):

Would you consider yourself to have a sugar, caffeine, nicotine or drug addiction?

Yes: No:

Do you have a strong preference for, or aversion to, any foods or drinks? (specify):

What diet or nutritional program do you follow? (Example: vegetarian, macrobiotic, meat & potatoes, etc.).

Do you generally cook your own food? Yes: No:

Please describe your general diet: -----

Breakfasts:

Snacks:

Lunches:

Drinks:

Dinners:

PLEASE NOTE THIS IS A PRELIMINARY QUESTIONNAIRE AND MORE QUESTIONS WILL MOST LIKELY BE NECESSARY AS WE EXPLORE THE OPTIONS FOR SUPPORT. IT MAY BE HELPFUL, GIVEN I CANNOT ASSESS YOU IN PERSON, IF YOU CAN PROVIDE PICTURES, FOR EXAMPLE OF SKIN ISSUES, AND OFTEN I CAN MAKE TONGUE DIAGNOSIS VIA JUST A PICTURE AS WELL. Let me know if this is comfortable for you. 😊

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