GOLDROOT BOTANICAL MEDICINE

Initial Intake Form

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My role as an herbalist is to help educate and empower you to connect more deeply with your authentic self and to be a partner & ally in helping you develop your own connection to the healing plants. As such, I am not medically trained and do not diagnose or treat diseases. *This detailed intake form has many questions that may or may not pertain to your condition. Complete the sections and questions that are relevant to your current situation. Everything on this form is completely confidential.*

Name:_____ Date: _____

Date of Birth: _____ Preferred pronoun(s): _____

Ph: _____ Email: _____

Address: _____

Height: _____ Weight: _____ Relationship status: _____

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

Main reason for visit (symptoms, diagnoses, main complaints)

Other health issues:

Are you sensitive to any medications? If so, please list them below.

Current medications and treatments:

Could you possibly be pregnant? (Y/N)

Are you currently breastfeeding? (Y/N)

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

Drug History
Please list any drugs, prescription or otherwise, you have used or are using.

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
____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
____Immunodeficiency
____Infections
____Low grade fever
____Lowered resistance
____Lupus (SLE)
____Mononucleosis
____Myasthenia gravis
____Pernicious anemia
____Rheumatoid arthritis
____Sick often
____Sore throats
____Swollen lymph glands

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?

Diet
Please fill in the below chart using the following scale:
F –Frequently consume (daily/more)
O– Occasionally consume (few times weekly)
I – Irregularly consume (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)

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, and 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, '**S**' if you suspect it and '**?**' if you're unsure.

____Bacterial vaginosis
____Benign Prostatic Hyperplasia (BPH)
____Blood in semen
____Blood in urine
____Breast pain
____Cervical dysplasia
____Cysts
____Difficulty urinating
____Dribbling
____Endometriosis
____Erectile dysfunction
____Fibroids
____Frequent urination
____Impotence
____Infertility
____Interrupted flow of urine
____Miscarriage
____Painful ejaculation
____Painful intercourse
____Painful to urinate
____Pelvic inflammatory disease
____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?

For men: 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
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? Please indicate any symptoms that pertain to you.
____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_____

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 that pertain to you.

____Bloody
____Dry cough
____Hacking
____Itchy throat
____Painful
____Persistent
____Regularly
____Wet cough
____Worse at morning, afternoon, evening, night (circle)

Are there any other concerns you wish to share? (Please feel free to use additional sheets if necessary.)