New Client Intake Form

Instructions for your first herbal consultation

Thank you for giving thoughtful consideration as you complete the enclosed New Client Questionnaire. You will have ample opportunity to address any concerns that require more detail during your appointment with your practitioner. Client confidentiality will be observed under all circumstances.

Required for your first visit:

- The completed New Client Questionnaire.
- Any labs, blood tests, or pertinent information you think may be helpful.

Personal Information

Name: _____ Phone: _____

Address: _____

Email: _____

Age: _____ Sex: _____ Date of Birth: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

What are your primary reasons for coming in?

1. _____
2. _____
3. _____

Occupation & Interests

Occupation: _____ How Long? _____

Do you enjoy your work? _____

What are your interests/passions? _____

What is your Religious/Spiritual preference? _____

Relationship Information

Status: _____ Partner's Name & Gender: _____

Medical Information

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

What health concerns did you experience as a child?

What health concerns have you experienced as an adult?

Do you have any allergies to food, medications, chemicals, and/or other environmental substances? If so, which ones?

What, if any, surgeries/operations have you undergone, and when?

What types of health practitioners are you currently working with?

For Women: **Pregnancies *(please include losses/terminations)***

Year	Vaginal/ C Section	Sex	Complications/Other Things You Want to Mention

Medications, Vitamins, Minerals & Herbal Supplements

Name	Dosage	Frequency	Length of Time	Reasons for Taking

Are you sensitive to low levels of medication(s) and/or caffeine? _____

_____

_____

Review of Body Systems: Please indicate any of the following items that you are currently experiencing or that is relevant to your current health. Also, provide answers to those items marked with a question mark.

Head
- ☐ seizures
- ☐ headaches
- ☐ migraines

Eyes
- ☐ vision loss
- ☐ tearing
- ☐ discharge
- ☐ redness
- ☐ pain
- ☐ corrective lenses

Ears
- ☐ hearing loss
- ☐ tinnitus
- ☐ discharge
- ☐ itching
- ☐ freq. infection

Nose
- ☐ discharge
- ☐ blood
- ☐ congestion

Neck & Throat
- ☐ pain
- ☐ lump
- ☐ enlarged thyroid
- ☐ stiffness
- ☐ tonsillitis

Lymph Nodes
- ☐ congestion
- ☐ swollen
- ☐ painful
- ☐ infection
- ☐ drainage

Endocrine
- ☐ low energy level
- ☐ hypothyroid(low)
- ☐ hyperthyroid(high)
- ☐ low blood sugar
- ☐ diabetes

Female Reproductive

Breasts
- ☐ tenderness
- ☐ lumps
- ☐ discharge
- ☐ changes in shape
- ☐ self-breast exams?
- ☐ other abnormalities
- ☐ mammograms?

Genitals
- ☐ vaginal discharge
- ☐ recurrent yeast infections
- ☐ STDs
- ☐ pelvic pain or masses
- ☐ painful intercourse
- ☐ low libido

Menses

Age at onset of menses?

_____

Length of menstrual cycle?

_____ days

Amount of bleeding?
- ☐ light
- ☐ moderate
- ☐ heavy

Quality of bleeding?
- ☐ bright red
- ☐ brown
- ☐ clotting

- ☐ painful cramps
- ☐ bleeding bet. cycles
- ☐ mood swings
- ☐ absence of cycle
- ☐ birth control, what form?

_____

Menopausal women

Age of menopause?

_____
- ☐ menopausal anxiety
- ☐ vaginal bleeding
- ☐ vaginal dryness
- ☐ hormone replacement therapy (HRT)
- ☐ osteoporosis

Male Reproductive
- ☐ difficulty with urination
- ☐ BPH
- ☐ genital masses
- ☐ penile discharge
- ☐ prostate pain
- ☐ testicle pain or swelling
- ☐ vasectomy
- ☐ erectile insufficiency
- ☐ painful intercourse
- ☐ burning on ejaculation
- ☐ low sperm count
- ☐ poor sperm motility
- ☐ low libido
- ☐ STDs
- ☐ birth control, what form?

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart palpitations
- ☐ rapid heartbeat
- ☐ chest pain
- ☐ high cholesterol
- ☐ varicose veins
- ☐ cold hands & feet
- ☐ stroke
- ☐ clotting tendency

Respiratory
- ☐ congestion
- ☐ sinus pain/inflammation
- ☐ difficulty breathing
- ☐ cough
- ☐ wheezing
- ☐ tuberculosis

Allergic & Immunologic
- ☐ respiratory allergies
- ☐ frequent colds or flu
- ☐ food allergies
- ☐ food sensitivities
- ☐ immune disorder

Musculoskeletal
- ☐ myalgia
- ☐ arthritis
- ☐ stiffness
- ☐ joint pain
- ☐ gout
- ☐ back pain
- ☐ poor mobility

Gastrointestinal
- ☐ bad breath
- ☐ mouth ulcers
- ☐ bloating ☐ pain/cramps
- ☐ gas ☐ nausea
- ☐ diarrhea ☐ constipation
- ☐ acid reflux/GERD
- ☐ undigested food in stool
- ☐ blood in stools
- ☐ ulcers ☐ polyps
- ☐ hemorrhoids
- ☐ gall stones
- ☐ liver/gallbladder issues

Bowel movements

Per day? _____

Per week? _____

Quality
- ☐ pebbly
- ☐ fully formed
- ☐ soft & largely unformed
- ☐ loose & unformed
- ☐ float or ☐ sink

Color?
- ☐ cardboard brown
- ☐ green
- ☐ dark/black

Urinary

Urinations per day?

_____

Color of urine?

_____
- ☐ bladder infection
- ☐ kidney infection
- ☐ kidney stones
- ☐ ankle or leg swelling
- ☐ incontinence
- ☐ urgency / frequency
- ☐ painful urination

Skin
- ☐ rash
- ☐ dry skin
- ☐ itching
- ☐ acne
- ☐ rosacea
- ☐ changing moles
- ☐ bruise easily
- ☐ hair loss

Stress

On a scale from 1-10, with 1 being low and 10 being high, how stressful is your:
Work: ____ Social/family situation: _____ Current health status: _____ Life in general: _____

Do you feel that your current state of health is?
☐ largely in your control ☐ largely out of your control

How do you manage stress? _____

Do you experience:
☐ Anxiety ☐ Stress ☐ Attention deficit
☐ Depression ☐ Panic attacks ☐ Mental sluggishness

What Moods Do You Experience Frequently?

__ accepting __ anxious or nervous __ angry __ capable __ compassionate __ determined
__ dreadful __ empowered __ enthusiastic __ fortunate __ guilty __ happy __ hopeful
__ hurt __ inspired __ lonely __ loved __ peaceful __ resentful __ resigned __ sad
__ scared __ terrified __ tired __ uncertain

Food and Drink

How many times each week do you eat at home (vs. out)? _____

How many ounces of water do you drink per day? _____

Do you have a diet preference (vegan, vegetarian, pescatarian)? _____

What flavor do you crave (sweet, salty, bitter spicy, sour)? _____

Sleep

At what time are you typically in bed? _____ What time do you fall asleep? _____

Typical hours of sleep? _____ Number of times you awaken during the night. _____

Reason(s) why you wake during the night _____

Do you wake to an alarm clock? _____ Do you feel rested upon rising? _____

Please email it to gina@herbsandowls.com.

DISCLOSURE/INFORMED CONSENT FORM

I, Gina Kearney, am a Registered Herbalist (RH) with the American Herbalist Guild & Certified Flower Essence Practitioner. I am also a member of the Flower Essence Society (FES).

Currently, herbalism is not considered a recognized health care modality in Florida. As such, there is no state or national licensing for herbal practitioners. At this time, there is only national certification and registration.

I received my Herbalist Certification from the ArborVitae School of Traditional Herbalism and Delta Gardens and am a Registered Flower Essence Practitioner with the Flower Essence Society (FES). My training includes Traditional Chinese Medicine, Ayurveda (India), Eclectic herbalism (early American), European phytotherapy, Flower Essence Therapy and some traditional Native American herbalism. I am also trained in Shamanic Healing and Energy Medicine and am ordained by the Universal Life Church Ministries.

My basic approach is to combine alternative healing methods with the latest scientific findings and clinical practices. Because each client is unique, I will use various methods in my work with you. My basic healing philosophy is to offer you the support needed to restore your ability to experience balance and harmony in your health. The focus of my assessment of your health is to focus on identifying patterns of strength and weakness. Using this information, depending on your wishes, I will make recommendations that may include flower essences, nutrition, herbs, supplements, counseling and lifestyle. My recommendation may also include suggestions for creating physical, emotional, mental and/or spiritual balance.

I am NOT a medical doctor nor do I practice standard Western medical assessment, diagnosis or treatment. I do not claim to cure disease, nor do I offer advice about the use of any type of pharmaceuticals or medications at any time. I have no objections to my clients being seen or evaluated by their own medical doctor. If you have any questions or concerns about your health, I highly recommend you discuss them with your physician. I encourage you to share and discuss my recommendations with any other health care professionals.

Further, I may recommend suppliers of high quality, pure herbs and/or maintain an herbal/nutritional apothecary in my clinic. I may sell herbal products, nutritional supplements and food products for a profit. I dispense them as a convenience and to ensure patients are receiving specific, individualized herbal formulas and quality herbal remedies. I order only high quality, pure herbs from around the world (India, China, rainforest, etc.) Herbal formulas may include wild herbs I have personally harvested and made into medicinal preparations by hand. I often use these preparations to create custom herbal formulas for individual clients. Clients are not obligated to buy any products from my clinic and I encourage clients to purchase supplements wherever it is most convenient for them. The recommended nutritional/herbal supplements I suggest are not a replacement for the medications prescribed by your Medical Doctor.

I am available to discuss any questions or concerns you may have. Please indicate that you have read and understand the information on this form by providing your signature below.

Name (Signature):_____ Date:_____

Name (Print): _____