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

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

Occupation __________________________ Partner Status ________________ Children (#/ages) ______________________

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?

____

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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 __________________________