

**Katolen Yardley, MNIMH, Medical Herbalist
Clinic Intake Form and Health Profile**

Confidential Health Inventory

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

Do you wish to be informed of our periodic vacation and out-of-office dates by email, in order to ensure you will not run out of product during this time and can schedule your follow up appointments ? Yes / No

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

Occupation _____ Partner Status _____ Children (#/ages) _____

Do you have extended medical coverage? Provider _____ Policy Number _____

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
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 than 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

- | | | | |
|---------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Poor healing sores | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Recent moles | <input type="checkbox"/> Change in skin texture | <input type="checkbox"/> Varicose veins | |

Any other noted problems with skin, nails or hair? _____

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Clicking jaw | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Mucous in throat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Root canals? How many? _____ | | |

Any other problems with the head? _____

Cardiovascular

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Breathing difficulties |

Any other problems with the heart or circulation? _____

What is your blood pressure? _____

Gastro-Intestinal

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Gas | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Mucous in stools |
| <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Haemorrhoids | <input type="checkbox"/> Bloating | <input type="checkbox"/> Food cravings |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Colitis/ IBS | <input type="checkbox"/> 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 often?

Enemas Laxatives Purgatives What type/brand? _____

Any other digestive problems? _____

Respiratory

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain on breathing | <input type="checkbox"/> Shortness of breath without exertion | |
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Production of phlegm, if yes what color? _____ | | |

Any other problems with breathing? _____

Urinary

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency of urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Irregular flow |
| <input type="checkbox"/> Impotency | <input type="checkbox"/> Inability to hold urine | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Water retention | <input type="checkbox"/> Burning urine | <input type="checkbox"/> Difficulty stopping or starting |
| <input type="checkbox"/> Prostate enlargement | <input type="checkbox"/> Interstitial cystitis | |

Any other problems with urination? _____

Musculoskeletal

- | | | | |
|--|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Reduced range of movement | |

Do you see a Chiropractor or Massage Therapist (name)? _____

Any other musculoskeletal problems? _____

Reproductive

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Age of first period | <input type="checkbox"/> Length of cycle | <input type="checkbox"/> Duration of bleeding | <input type="checkbox"/> Clotting |
| <input type="checkbox"/> Light Flow | <input type="checkbox"/> Color of Blood | <input type="checkbox"/> Heavy Bleeding | <input type="checkbox"/> Irregular Bleeding |
| <input type="checkbox"/> Severe menstrual cramps | <input type="checkbox"/> Discharge | <input type="checkbox"/> Color of Discharge | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Uterine cysts | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Dry vaginal lining | <input type="checkbox"/> Osteoperosis | <input type="checkbox"/> ERT therapy |
| <input type="checkbox"/> Break through bleeding | <input type="checkbox"/> Dramatic mood swings | <input type="checkbox"/> Absence of cycle | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Pain with intercourse | <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> 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 _____

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> # of pregnancies | <input type="checkbox"/> # of births | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> Terminations | <input type="checkbox"/> 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? _____

For Men Only: Check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Pain or swelling of the testicles | <input type="checkbox"/> Frequent need to urinate at night | <input type="checkbox"/> Difficulty with orgasm |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Pain of testicles | <input type="checkbox"/> Impotence/erectile dysfunction |
| <input type="checkbox"/> Feeling of coldness or numbness in genitalia | <input type="checkbox"/> Other bothersome urinary symptoms | |

Do you get up at night to urinate? ___ Yes ___ No --- if Yes, How often? _____

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 or 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

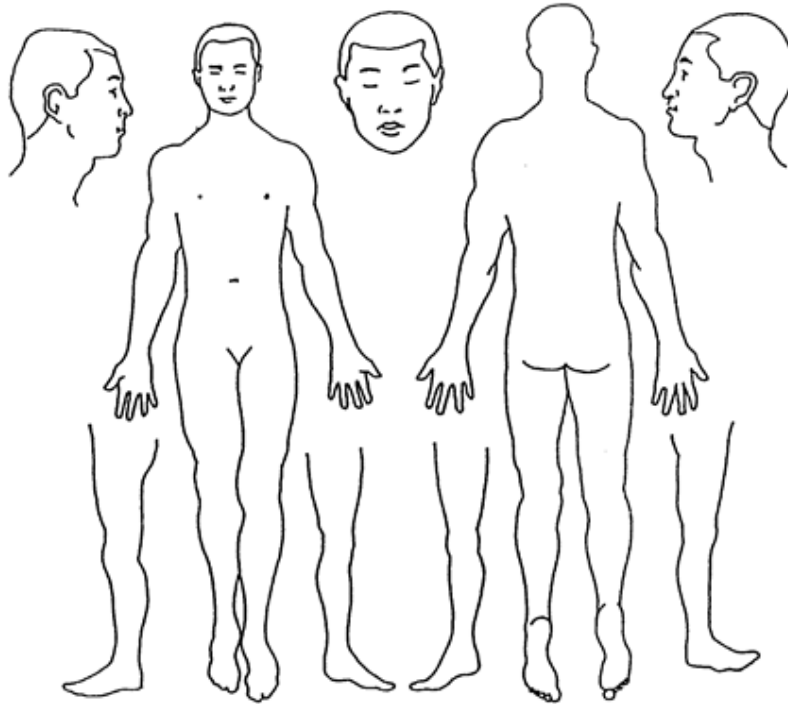
How do you feel about the following areas of your life? Please check appropriate boxes and make any comments you would like to

	EXCELLENT	GOOD	FAIR	POOR	COMMENTS
Self					
Work					
Spouse or significant other					
Sex					
Family					
Personal Goals/ Life Purpose					

Pain

Are you currently dealing with any pain(s) ? Yes No If YES, please indicate painful or distressed areas on body map on the next page.

Area/ Description of Symptoms	Pain Level: 0 TO 10	Frequency (10 Being the highest)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Stress Level

PERSONAL STRESS

- 1. I worry a great deal Yes No
- 2. I feel lonely Yes No
- 3. I am bored with my life Yes No
- 4. I think a lot about dying Yes No
- 5. I have particular concerns relating to my religion Yes No
- 6. I feel fearful or afraid Yes No
- 7. I feel nervous most of the time Yes No
- 8. I often feel depressed Yes No
- 9. I feel anxious often Yes No
- 10. I am ill frequently Yes No
- 11. I sometimes feel weak or light-headed Yes No
- 12. I often have pains in my shoulders, neck or back Yes No
- 13. I often feel like crying Yes No
- 14. I lose my temper more than I used to Yes No

Other personal concerns Yes No

Please describe _____

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?

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 the names individual is not a medical doctor and understand that there will be no diagnosis made, nor prescription given. I affirm that I am consulting with this practitioner for educational purposes, of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the above named practitioner will offer an assessment of my general state of 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. I agree to the cancellation policy of this clinic:

Full fee will be charged for missed appointments and for appointments cancelled with less than two (2) working days notice.

Signature _____ Date _____

Clinical Research

For the purposes of research and continuing education, it is occasionally helpful for practitioners to review case files and to discuss cases with colleagues, or to publish specific information in professional journals where there are important lessons to be learned from a case. I would like to ask your permission to potentially use selected information from this file for such purposes. At all times identifying features will be kept private and no confidential information will be divulged. This is strictly for the purposes of learning and teaching.

Please indicate below if you give permission for such research use:

I give my permission for selected information in this file to be used for continuing learning purposes.

I do NOT give my permission for selected information in this file to be used for continuing learning purposes.