Kenton Cobb, Herbalist
kenton@phytoamorous.com
267.606.0750

Name: Date:

DOB: Age:

Address: Email:

Telephone: Best times to call:

This intake form is designed to provide insight into your health and health history by looking at the whole of your body, mind, diet, habits, stressors, symptoms and so forth. Drawing on many aspects can evidence patterns and tendencies helpful in understanding the current illness from a holistic perspective. Thus, there are number of questions which may not seem pertinent to your current health concern. Despite this, please answer as much as you are able and are comfortable with, and mark anything you would rather speak about in-person. All information is held strictly confidential and will not be shared with anyone except with your release or request. Thank you!

What is your current gender identity? (circle all that apply)

- ☐ Female
- ☐ Transgender Male/Transman/FTM
- ☐ Transgender Female/Transwoman/MTF
- ☐ Decline to answer
- ☐ Male
- ☐ Genderqueer
- ☐ Additional category (please specify):

What sex were you assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Decline to answer

What pronouns do you use/how would you like to be referred to?

What are the health concerns that you want to address?

Current health practitioner(s) you work with *(name, modality, any diagnoses):*

Current prescription *and* over-the-counter medications, herbs, or supplements

Med/Supp/Herb Brand Name Potency(mg/ iu) Dose Frequency Duration Helpful Side Effects?

Dietary Summary

Outline a typical day. Include normal time ranges for meals and snacks.

Breakfast	
Lunch	
Dinner	
Snacks	

Discuss your eating schedule/habits (include snacks, etc):

Typical eating environment (at home, at work, sitting, standing, while driving, etc…):

How often do you prepare your own food?

Food cravings:

Food preferences (circle all that apply)

☐ sweet ☐ sour ☐ salty ☐ bitter ☐ spicy ☐ oily ☐ cooked ☐ raw

Known or suspected food allergies/intolerances/sensitivities:

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 special diet? Please describe and indicate when:

Daily water intake amount: Other fluids amount (eg. juice, soda):

Frequency of consumption (how many servings/week)

	bread/pasta/wheat/gluten		sweets		eating out
	fast food		soda		fresh fruits
	dairy (eg. milk, cheese, yogurt)		fresh vegetables		fried foods
	soy		animal protein		coffee

Medical and Family History:

Weight: Weight 1 year ago:

Height: How many siblings? What number in birth order?

For the following, please include dates and length of illness and recovery:

Major injuries/illnesses:

Surgical operations:

Other hospitalization:

Recent illness:

Childhood illness(es):

Do you smoke/chew tobacco? How much? How long?

Have you used tobacco in the past? When? How long?

Do you drink alcohol? How much? How often?

Do you use recreational drugs? How much? How often?

Please list any allergies to medications, chemicals, and environmental factors (pollen, dust, etc)

Please complete this section only for any family members with particular health problems.

	Age (if deceased age of death)	Health Problem
Father		
Mother		
Siblings		
Children		
Other		

For the following, please check any that apply, and provide additional information as needed:

Digestive health

☐Poor appetite
☐Periodontal disease
☐Frequent burping
☐Heartburn
☐Gas
☐Intestinal pain/cramping
☐Incomplete digestion
☐Mouth frequently too dry
☐Indigestion after eating
☐Duodenal ulcer
☐Acid indigestion/reflux
☐Stomach ulcer
☐Bad breath in AM
☐Nausea
☐Cavities
☐Stomach pain/cramping
☐Acid reflux
☐Bloating
☐Frequent antibiotic use
☐Constipation
☐Diarrhea
☐Frequent burping
☐Bitter taste in AM
☐Oily stool
☐Often don't finish meals
☐Often eat to calm down
☐Blood in stool
☐Sometimes nausea in AM
☐Difficulty in swallowing
☐Sometimes nausea in PM
☐Mouth or cold sores
☐Butterflies in stomach
☐Strong Demanding hunger
☐Seldom eat breakfast
☐Frequent use of Alcohol
☐Constipation and diarrhea alternating

Frequency of bowel movements:

Quality of bowel movements (color/consistency):

Kidney and urinary system health

☐Dull pain in lower back
☐Kidney stones
☐Yeast infection(s)
☐Bladder control problems
☐Painful urination
☐Frequent thirst
☐Swelling in hands/feet
☐Urinary tract infection(s)
☐Water retention
☐Frequent urination
☐Decreased urine flow

Frequency of urination:

Quality of urine (color/odor):

Respiratory system health

☐Nasal congestion (when?)
☐Asthma
☐Bronchitis (when?)
☐Pneumonia (when?)
☐Tuberculosis (when?)
☐Frequent lung congestion
☐Stuffiness
☐Sinus infections
☐Wheezing upon exertion
☐Hoarseness/sore throat
☐Shortness of breath
☐Recurrent cough
☐Hyperventilation

Mucus production in nose and/or lungs?

How often?

Color of mucus:

Thickness:

Muscle/bone/joint health

☐Cavities
☐Osteoporosis
☐Muscle pain
☐Carpel tunnel
☐Arthritis
☐Torn ligaments/tendons/frequent sprains
☐Results of bone density test (if applicable):
☐Brittle nails
☐Broken bones
☐Poor flexibility
☐Tendonitis
☐Chronic swelling/inflammation
☐Joint stiffness

Energy reserves and stress:

☐Fatigue
☐Low energy in morning
☐Low energy in afternoon
☐Use relaxation techniques
☐Low energy in evening
☐Job stress
☐Debilitating disease
☐Easily tired
☐Pain to touch
☐Ongoing stressors
☐Need coffee to get started
☐Anemia
☐Family stress
☐Current or past trauma

Favorite time of the day: Of year:

Exercise frequency, type, and duration:

Normal bedtime: Weekday: Weekend:
Normal waking time: Weekday: Weekend:

Tell me about your sleep:

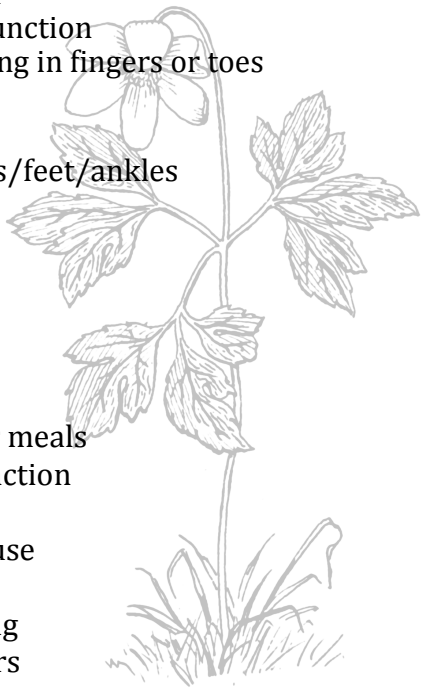
When you get sick/have problems, where/how does that typically happen?

Specific stressors right now:

How do you deal with stress?

Cardiovascular health

☐High blood pressure
☐Stroke
☐Atherosclerosis
☐Arrythmia
☐Cold hands/feet
☐Bruise easily
☐Rarely sweat
☐Pain/cramping in legs
☐wounds/ulcerations on feet/legs
☐High triglycerides
☐Blood pressure:
☐Heart attack
☐Congestive heart failure
☐Heart palpitation
☐Heart valve dysfunction
☐Numbness/tingling in fingers or toes
☐Sweat easily
☐Varicose veins
☐Swelling in hands/feet/ankles
☐Palpatations
☐Bruise Easily



Metabolic function

☐Diabetes/pre-diabetic/insulin resistant
☐Light-headed before meals
☐Thyroid disease/dysfunction
☐Hepatitis
☐Jaundice
☐Frequently hot
☐"Sugar Crashes"
☐Abdominal pain
☐Fasting blood glucose level (if known):
☐Cirrhosis
☐"Heaviness" after meals
☐Hormonal dysfunction
☐Hypoglycemia
☐Alcohol/drug abuse
☐Frequently cold
☐Frequent snacking
☐Ringing in the ears

Immune function:

☐Frequent illness
☐Fever (temperature)
☐Dust allergies
☐Pet allergies
☐Reactions to vaccines
☐Muscle tenderness/soreness
☐Recurrent infections
☐Wounds heal slowly/prone to infection
☐Seasonal allergies
☐Mold allergies
☐Chemical sensitivity
☐Sensitivity to medication
☐Joint tenderness/soreness
☐Recurrent rashes/skin irritation

Immunization(s) received:

Chronic conditions:

Nervous system:

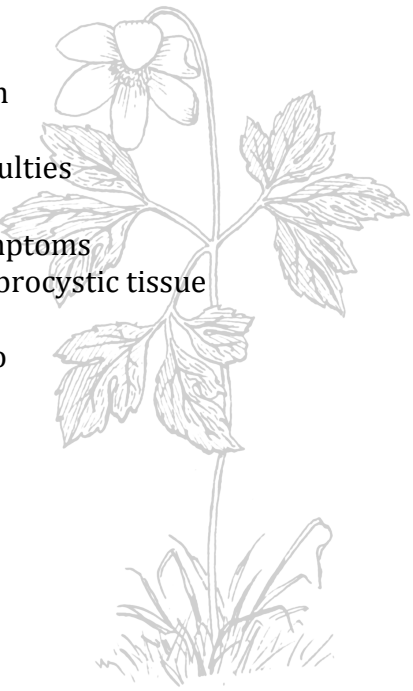
☐Tired upon waking
☐Anxiety
☐Depression
☐Head injury
☐"Pinched nerve"
☐Trauma
☐Radiating or shooting pain
☐Tremors/shaking
☐Chronic tension
☐Dreams
☐Panic attacks
☐Spinal injury
☐Herniated disks
☐Paralysis
☐Numbness/tingling
☐Sciatic nerve pain
☐Poor muscle control
☐Constantly frazzled

Headache/pain recurrence: daily weekly monthly seasonal

Aggravating factor(s) for headache/pain recurrence:

Genital/Endocrine

☐Erectile dysfunction (impotence)
☐Urinary difficulties
☐Prostatitis (BPH)
☐Testicular cancer
☐Hormone replacement
☐Using birth control medication
☐Uterine fibroids
☐Endometriosis
☐Breast tenderness
☐Sexually active
☐Hot flashes
☐Painful intercourse
☐Infertility
☐Sexually active
☐Prostate cancer
☐Painful ejaculation
☐Infertility
☐Menopausal difficulties
☐Uterine cysts
☐Premenstrual symptoms
☐Breast lump(s)/fibrocystic tissue
☐Underactive libido
☐Overactive libido



Uterine

Results of last gynecological exam/pap smear:

Menstrual cycle (if not menstruating, describe your cycle in the past):

Duration (days): Frequency (days): Regular?

Blood Flow (heavy/med/light etc): Clotting?

Number of pregnancies: Number of births: Miscarriages:

Pre-mature births: Terminations:

Do you have any children? Age(s):

Is there any chance that you are currently pregnant?

Contraceptive History: List the kind(s) if contraceptives you have used, if any, and for how long:

☐Birth Control pills ☐IUD ☐Condoms ☐Mucous method
☐Chemical spermicides ☐Diaphragm ☐Rhythm

Any other gynecological problems?

Please feel free to add any other information or thoughts about your physical health:

Current Emotional/Spiritual/Community health:

What are the predominant emotions in your life?

Rate how you feel about the following areas of your life (0 – poor 10 excellent)

	1 to 10	Comments
Self		
Family		
Friends		
Partner(s)		
Community		
Work		
Personal goal		

Do you have a network for support you can call on?

What do you worry about?

What do you do for fun? What do you do to relax?

I always wanted to be:

I always wanted to do:

Is there one thing in your life you would like to change right now? Can you change it?

What is your desired goal for your clinic visit?

Ideally, what state of health can you visualize achieving for yourself?

Please attach results of lab work and any relevant testing.