



CONFIDENTIAL HEALTH AND LIFESTYLE INTAKE FORM

rkherbclinic@gmail.com Mob. 086 1939235

Dear Patient:

Thank you.

This form is **completely optional** but it allows for a very comprehensive overview of any symptoms you may be experiencing. If completed with care, your answers will help me determine the most effective care for you as quickly as possible.

Any questions that you would rather discuss in person can be marked-off for discussion.

I appreciate you taking the time to fill this form prior to our visit and please bring the completed form with you when you come, or email it to me, before your appointment.

PT#:	
WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER?	YES or NO. Please circle your choice.
PATIENT I	NFORMATION
DATE OF FIRST CONSULTATION	How did you hear about me?
NAME:	AGE: DATE OF BIRTH:
ADDRESS:	
PHONE MOBILE	EMAIL
MARITAL STATUS: S M SEP DIV	_ WID
NUMBER OF CHILDREN AGES	GENDER
OCCUPATION:	
IF CLIENT IS A CHILD, GIVE THE PARENT'S NAMES:	
MOTUED	HED



What has most helped your allergies?

Dr. Rosarie Kingston PhD., MSc (Herbal medicine)



GENERAL INFORMATION Height ______ weight _____ weight one year ago _____ Do/did you smoke? _____ How long? _____ How many per day? _____ Do you drink alcohol? _____ What kind? _____ How often? _____ Do you drink coffee or tea (caffeinated)? _____ How many per day? _____ Do you use recreational drugs? _____ What kind? _____ How often? _____ Do you exercise regularly? _____how often? _____ What type? _____ What are your hobbies, skills, interests, and/or favourite pastimes? How would you generally describe your current health? ALLERGIES OR SENSITIVITIES DO YOU HAVE ANY ALLERGIES OR SENSITIVITIES? If yes, please list them. Examples: drugs, foods, environmental? Which medicines (including herbal) have you taken for them? When, where, and time of year, are your allergies least and most troublesome?







WHAT IS WORRYING YOU ABOUT YOUR HEALTH CURRENTLY, THAT PROMPTED YOUR CONSULTATION WITH ME? Please describe all the symptoms in as much detail as possible. Has there been a western medical diagnosis? When did the symptoms first begin? Are they getting worse? What makes it worse or better? How severe are the symptoms? What is the timing, frequency, duration of symptoms? Is there a pattern to the symptoms? What is the relationship between various symptoms?

(Please include any significant lab reports):





ARE YOU CURRENTLY ON ANY MEDICATION(S), PRESCRIPTION, TREATMENTS OR OTHERWISE?

Example: laxatives, cortisone, pain relievers, tranquillisers, thyroid medication, hypotensive drugs, etc. or other treatments or therapies.

if yes, please list them and give dosage.

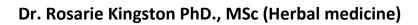
NAME OF DRUG	DOSAGE

Are you happy with the results of the treatment(s):

ARE YOU CURRENTLY TAKING ANY NUTRITIONAL SUPPLEMENTS, VITAMINS, MINERALS OR OTHER HEALTH PRODUCTS? If yes, please list them and the dosage:

NAME OF SUPPLEMENT/VITAMINS/OTHER HEALTH PRODUCTS	DOSAGE







ARE YOU CURRENTLY SEEING ANY OTHER HEALTH CARE PROFESSIONALS? Y	ES NO
Their Profession	

HEALTH HISTORY

PLEASE CHECK ANY OF THE BELOW SYMPTOMS OR DISEASES YOU HAVE EXPERIENCED.

Use a scale of 1-5, 1 the least and, 5 being the most severe. If unsure, use a question mark '?'

AD(H)D	AIDS	Alcoholism	Allergies
Anaemia	Anxiety	Arthritis	Asthma
Bloating	Cancer	Chemical sensitivities	Chronic fatigue
Common cold	Constipation	Depression	Diabetes
Diarrhoea	Dizziness	Drug abuse	Environmental
			sensitivities
Epilepsy	Epstein-Barr virus	Excess stress	Eyesight problems
Fatigue	Gynaecological	Headaches	Hearing problems
	problems		
Heart disease	Hepatitis A, B, or C	High blood pressure	HIV
Hyperglycaemia	Hypoglycaemia	Immune disorders	_Injuries
Low blood pressure	Male health	Memory loss	Menopause
	problems		problems
Menstrual	Numbness	Painful joints	Rashes
irregularities			
Respiratory problems	_Seizures	Shingles	Shortness of breath
Sleep problems	Sore throats	Stiffness	Stomach aches
Swelling	Tumours	Urinary tract infections	Other







PREVIOUS MEDICATIONS AND TREATMENTS

HAVE YOU EVER BEEN HOSPITALIZED, HAD ANY OPERATIONS OR ACCIDENTS INCLUDING AUTOMOBILE? Please give the dates and reasons.

HOSPITALISATION/OPERATION	DATE	REASON

HAVE YOU HAD ANY DIAGNOSTIC TESTS OR PROCEDURES OVER THE PAST 2 YEARS? Example: x-rays, cat scans, MRI, blood tests, etc. If yes, please list dates and results.

TEST	DATE	RESULT	

IMMUNIZATIONS

Please give dates if possible:

polio	tetanus / whooping cough / diphtheria
flu shot	measles / mumps / rubella
Other	





IMMUNE SYSTEM. Please mark,

'P' for previous condition,

'C' for current and

'?' if unsure.

Adenitis	Allergies	Autoimmune disorders	Catch everything
Chronic fatigue	Enlarged spleen	Graves disease	Hashimoto's thyroiditis
Heal slowly	Immunodeficiency	Infections	Low grade fever
Lowered resistance	Lupus (SLE)	Mononucleosis	Myasthenia gravis
Pernicious anaemia	Rheumatoid arthritis	White blood cell count	Sore throats
Swollen lymph glands			

Do you have any concerns about your immune system?

CHILDHOOD ILLNESSES, DISEASES AND SYNDROMES

Allergies	Asthma	Atopic eczema
Bronchitis	Chicken pox	Ear infections
German measles (Rubella)	Measles	Mononucleosis
Mumps	Rheumatic fever	Tonsillitis
Whooping cough (Pertussis)	Other	

FAMILY MEDICAL HISTORY

As there is sometimes a genetic disposition to health problems, it is useful to know if certain medical problems occur in close family members, for example, cancer, diabetes, heart disease, high blood pressure,





stroke, epilepsy, me	ntal illness, asthn	na, hay fever, ecz	ema, anaemia, gla	ucoma, kidney disea	se, etc. (if
deceased, age at dea	ath and cause of o	death)			
Father					
Mother					
Siblings					
GENERAL HEALTH E	NERGY LEVELS				
Are you satisfied wit	h your current er	nergy levels? If no	ot, please describe	:	
Have your energy led change? ———————————————————————————————————					
Arms	Hand		Palms	ne to these body are]
Fingers	Legs		Feet		
Genital region	Head		Chest		
Stomach	Gene	ral body			
Other: Using a scale of 1 (le Hot Very hot _ EMOTIONAL Use a scale of 1 (rare	Cold V	ery cold Da	mp Dry	_ Humid	
Angry	Anxious	Attentive	Bi-polar	Depressed	1
Dreamy	Enthusiastic	Fearful	Forgetful	Grumpy	

Inspired

Нарру

Lethargic

Manic

Nervous





Pessimistic	Sad	Worry a lot	

Other					
How would you desc	cribe your emotion	nal health generally	y? I.E good, ok, po	or, don't think abou	ut it,
relevant (Please circ	le your choice).				
How would you desc	cribe your spiritual	l health??I.E good	l, ok, poor, don't t	hink about it, not re	eleva
(Please circle your ch	noice).				
MEMORY AND CON	CENTRATION				
How is your long-ter	m and short-term	memory?			
Has your memory ch	nanged noticeably	in the past few yea	ars?		
How is your concent	ration?				
Has it changed? If so	o, when and in wha	at way?			
HEADACHES					
Do you ever have he	eadaches? If so, pl	ease give as much	detail as possible.		
How often?					
How long have you h	nad them?				
Location/type of hea	adaches?				
What triggers them	?				
Other symptoms ass	ociated with the h	neadache (i.e., stor	nach pain)?		
Are they more or les	is often than in the	e past?			
Does the severity or	intensity vary from	m anisoda to aniso	de?		





What medicines a	and treatments	have you	tried, which were r	most suc	cessful?	
Please check if the	e following app	у:				
After eating	Afternoon		Around eyes	Arour	nd temples	Aversion to stimuli
Back of head	Band aroun	d head	Before eating	Chror	nic	Cluster
Constant	Dull		Evening	Front	of head	Left side
Migraine	Morning		Night	Pound	ding	Pre-menstrual
Right side						
Fall asleep fast Sleep through th	n minht	Hard t	o fall and stay asle	ер	Restless slee	
			·	ер		•
Hard to fall aslee					Hard to wak	
asleep	ep, but stay	vvake	up to urinate		Haru to wak	e up
Bed before 11:00	0 pm	Bed be	efore 1:00 am		Up until 3.00) am
Uther						
Which are your fa	vourite hours to	o sleep? _		_		
Generally, how m	any hours of sle	ep do you	u need to feel reste	ed?		
Do vou feel reste	d when you wak	e in the n	norning?			





Dreams (circle those that apply)	/):
----------------------------------	-----

active, lucid, anxious, nightmares, probing, pleasant, interesting, scary,
other

REVIEW OF BODY SYSTEMS

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THESE IN LAST 3 MONTHS.

SKIN, HAIR AND NAILS Mark any of the conditions below that pertain to you.

Use 'P' for past problem and 'C' for current.

Acne	Boils	Bruise easily	Dandruff
Dry hair	Dry skin	Eczema/psoriasis	Hair loss
Hives	Impetigo	Itchy	Mole changes
Oily hair	Pimples	Rashes	Scars
Sensitive to chemicals	Skin tags	Slow to heal	Nail texture change
Brittle/cracking nails	Leg ulcers	Lines/ridges on nails	Varicose veins

EYES, EARS, NOSE, MOUTH AND THROAT

Eyes

Have previously had a problem use 'P' or currently have 'C'

Do you wear corrective lenses/glasses?				
does the prescription for your glasses/lenses change often?				
Glaucoma blurred vision eye pain				
cataracts	spots in front of eyes	Date of last eye examination		
Other				





Ears 'P' for previous or 'C' for current

Ear infections	Earaches	Hearing loss			
Overly sensitive	Tinnitus/ringing	Wax build up			
Other					
How is your hearing ? has it changed in the past years?					

Nose, Mouth & Throat Please list 'P' for previous or 'C' for current conditions.

Cavities	Constant dryness	Difficulty swallowing	Excess saliva
Lip sores	Loose teeth	Mouth sores	Oral herpes/cold sores
Painful jaw	Clicking jaw	Sore gums	Sore throats
Swollen glands	Swollen tongue	Mucous in throat	Canker sores
Grinding teeth	Sinus congestion	Change in sense of smel	I
Other	-	1	

CARDIO VASCULAR HEALTH Please use 'P' (past) or 'C' (current) if the conditions below are pertinent to your health:

Angina	Arrhythmias (irregular heartbeat)	Arteriosclerosis
Black and blue easily	Bleed easily	Blood clots
Cholesterol issues	Chest pains	Congenital deformities
Congestive heart failure	Oedema	Fast heart beat (tachycardia)
Heart flutter	Heart irregularities	Heart attack (myocardial infarction)
Heart murmur	High blood pressure	_lschemia
Low blood pressure	Mitral valve prolapse	Palpitation





Pericarditis	Poor circulation	Rheumatic fever
Slow heart beat (bradycardia)	Stroke	Varicose veins
pins and needles	swollen ankles and/or hands	pain/cramping in legs when walking
fainting	dizziness	shortness of breath on exertion
Phlebitis	Other	

ENDOCRINE SYSTEM Please use	'P' (past) or 'C' (current)	if the conditions below are	pertinent to your health:

thyroid problems	intolerance to heat or cold	excessive thirst
easy weight gain	hard to gain weight	light-headedness/dizziness
irritability/disoriented	hot flashes	sweatiness
sudden energy drops		

Symptoms when missed a meal (please list if so):
--

MUSCULOSKELETAL Please use 'P' (past) or 'C' (current) if the conditions below are pertinent to your health:

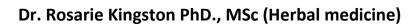
swollen joints	muscle pain	muscle weakness
neck pain	back pain	reduced range of motion
stiffness	joint pain	other

Have you had an injury or surgery on bone, muscle, tendon, cartilage or related issue?	Yes or No
Do you have any pins or other such items still inserted?	
If so, when and where?	

RESPIRATORY Please mark with a 'P' for previously a problem, 'C' for currently so, and '?' if unsure.

Asthma	Bronchitis	Chest pain or when breathing
Common cold	Coughing	Covid
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	

Have you identified foods, environment	al factors or situations that worsen yo	ur breathing? Yes or No
If so, what are they?		
Mucous (tick the symptoms which perta	in to you)	
Is mucous currently a problem? Yes_	No	
What is the quality and/or colour of the	e mucous:	
ClearGreenYellow	Thick/stickyThin/runn	у
Is it worse in the morning, afternoon, ev	rening, and/or night (circle)	
Do you have much congestion?	yesno	
Which season is it worse and best?		
What helps it?		
Cough (check the symptoms which pert	ain to you)	
Do you currently have a cough?	Yes No	
Bloody	Dry cough	Hacking
Itchy throat	Painful	Persistent
Regularly	Wet cough	
Worse at morning, afternoon, evening	and/or night (circle)	
Do you know of any things that trigger	the cough?_	





URINARY Please mark 'P' for previous and 'C' for current for any of the below conditions or '?':

Bloating	Blood in urine	Burning urination
Frequent urge to urinate	Kidney/bladder stones	Kidney pain
Lower back pain	Strong smelling urine	Water retention
Pain when urinating	Inability to hold urine	Other

Approximately how many times a day do you urinate?		
Describe your urine. What colour is it? Pale or deep colour. Is it cloudy or clear? (Please circle)		
Any smell? Do you w	rake up at night to urinate? Yes / No	
If so, how many times? Is it ever	difficult to urinate?	
After urinating, does it ever feel like you sti	Il have urine in your bladder?	
Have you had urinary tract infections?	How often?	

GASTRO-INTESTINAL

<u>Digestion:</u> Please use 'P' for previously, 'C' for currently or '?' for unsure.

Anorexia nervosa	Bulimia	Changes in bowel habits	Nausea
Crohn's disease	Constipation	Diverticulitis	Parasites (i.e. Giardia)
Dysentery	Eating disorders	Flatulence/gas	Food unappetizing
Gallstones	Vomiting	Heartburn	Haemorrhoids/rectal pain
Indigestion	I.B.S	Large appetite	Liver problems
Ulcer	Stomach-aches	Sudden weight change	Ulcerative colitis

Stomach pains	Burping	Intolerance to greasy foods
Stomach pains after meals	Fullness long after meals	Headaches after eating
Chronic abdominal pain	Bloating	Sour taste in mouth







Sudden, acute indigestion	Poor appetite	sleepiness after eating
Difficulty belching	Stomach upsets easily	Retain water

Abdominal cramps	Indigestion 1-3 hrs after eating	Seasonal diarrhoea
Fatigue after eating	Lower bowel gas	Frequent infections (colds)
Alternating constipation & diarrhoea	Diarrhoea	Bladder and kidney infections
Roughage & fibre cause constipation		Stool poorly formed
Abdominal cramps 3 or more large bowel movement		daily
Pain in left side under rib cage	Food allergies	Difficulty gaining weight
Other		

Bowel Movements (check the symptoms which pertain to you) ____

black stools	mucous in stools	blood in stools		
white or light grey stools	floating stools	sinking stools		
loose stools	hard stools	oily film on stools or in toilet bowl		
shiny stools	Other			
How many times a day do you have a bowel movement/defecate?				
Is your need to defecate urgent?				

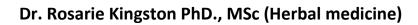
DIET - Please fill in the below chart using the following scale:

F – Frequently consume (daily or more) O– Occasionally consume (a few times/week)

I – Irregularly consume (less than once/week) D – Do not consume this

Wheat	Baked goods	Beef	Beer
Black tea	Bread	Cheese	Chicken
Cigarettes	Coffee	Eat out	Eggs
Fast food	Fermented foods	Fish	Fried foods
Fruit	Grains	Green tea	Herbal tea
Juice	Milk & milk products	Nut butters	Nuts/ seeds
Organic foods	Ppork	Potato chips	Refined flour/white flour







white sugar	Seafood	Seaweed	Spirits
Soda/Pepsi etc	Sweets	Vegetables cooked	Vegetables raw
Water	Wine	Other	

	evious	
hat are your favourite and lea	ast favourite foods?	
ow much do you drink everyo	lay? What do you drink?	
hat did you have for breakfas	t, lunch, and dinner yesterday?	
RVOUS SYSTEM AND STRESS	<u>3</u>	
ease mark with ' P' for previou	usly and ' C' currently to any conditions tha	at are pertinent to vou.
	.,,,	, , , , , , , , , , , , , , , , , , , ,
ease also follow a scale of 1 (r	noticeable but not a big problem) to 5 (ma	ajor problem).
	Τ	
nxiousness	Bipolar	Butterflies in stomach
	Bipolar Constant feeling of stress	Butterflies in stomach Diminished taste
Cannot stay asleep	·	
Cannot stay asleep Depression	Constant feeling of stress	Diminished taste
Cannot stay asleep Depression Hard to concentrate	Constant feeling of stress Fear of facing a new day	Diminished taste Fluctuating vision
Cannot stay asleep Depression Hard to concentrate Memory loss	Constant feeling of stress Fear of facing a new day Involuntary spasms	Diminished taste Fluctuating vision Mania
Anxiousness Cannot stay asleep Depression Hard to concentrate Memory loss Pain – constant Sudden mood swings	Constant feeling of stress Fear of facing a new day Involuntary spasms Nervousness	Diminished taste Fluctuating vision Mania Numbness
Cannot stay asleep Depression Hard to concentrate Memory loss Pain – constant	Constant feeling of stress Fear of facing a new day Involuntary spasms Nervousness Panic attacks Trouble falling asleep	Diminished taste Fluctuating vision Mania Numbness Seasonal affective disorder
Cannot stay asleep Depression Hard to concentrate Memory loss Pain – constant Sudden mood swings	Constant feeling of stress Fear of facing a new day Involuntary spasms Nervousness Panic attacks Trouble falling asleep	Diminished taste Fluctuating vision Mania Numbness Seasonal affective disorder Twitching

What goes wrong with your body when stress levels are elevated?





REPRODUCTIVE – MALE AND FEMALE

Have you had any of the following? Write 'P' for previously 'C' for currently, 'S' if you suspect you may have or '?' if you have a question about it:

AIDS	Candida	Chlamydia	Crabs/lice	Gardnerella
Genital warts	Gonorrhea	HIV	Syphilis	_STDs
Trichomonas	Urethritis	Human Papilloma Virus	Other	
		(HPV)		

REPRODUCTIVE - MALE

Have you had any of the following symptoms or conditions?

Use **'P'** for previously and **'C'** for currently or **'?'** if unsure.

Benign Prostatic Hyperplasia (BPH)	Blood in semen	Blood in urine
Difficulty getting urine flowing	Dribbling	Erectile dysfunction
Frequent urination	Impotence	Interrupted flow of urine
Libido low	Prostate pain	Painful ejaculation
Painful to urinate	Penis pain	Testicle pain
Vitality low	Other	
Do you get up at night to urinate? If	Does your prostate region ever hurt?	If yes, is pain dull, constant,
so, how often?		throbbing or sharp?
Is it ever painful to urinate? If so, desc	ribe the pain	
Does the urge to urinate interfere with	n your daily activities?	

REPRODUCTIVE – FE	ΞM	1AL	Е
-------------------	----	-----	---

Pregnancy Are you pregnan	t? If so, how many month	s?		
Are you trying to become p	regnant? If so, how long h	nave you been trying?		
Number of pregnancies	number of births	Premature births	miscarriages	





Use 'P' for past condition, 'C' for current, 'S' for unsure or '?' for any questions.

General

Breast pain	Cervical dysplasia	Cysts
Endometriosis	ndometriosis Fibroids Inf	
Miscarriage	Painful intercourse	Pelvic inflammatory disease (PID)
STDs	Tumours	_Unusual PAP
Vaginal discharge	Vaginal dryness	Vaginal infection
Vaginitis	Other	<u>'</u>

Menstrual Cycle

Acne	Bleeding between cycles	Mood swings		
Bloating (hands, stomach)	Bloating (feet, hands, ankles)	Irregular cycle		
Painful menses	mid cycle discomfort, bloating, pressi	mid cycle discomfort, bloating, pressure?		
PMS-if yes, describe symptoms:				
A+ f:+	Average number of days bleeding:	Approximately how many days		
Age at first period		11.		

Menstrual Blood

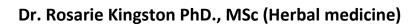
Bright red	Clots	Dark colour	Heavy flow
Profuse flow	Red	red brown	Scanty flow
Slow flowing	Mucousy	watery	Other

Menopause

Are you currently in pre, peri or post menopause? _____ Age when menopause began _____ Any of the following?

dry vaginal mucosa	Hormone replacement therapy	Hot flashes	Mood swings







Night sweats		Osteoporosis		Sore muscles	Other	
Contraception Method						
Birth control pills IUD		Diaphragm	Diaphragm temperature/mucous method		Other	
Are there any other concerns you wish to share? Please use this space or a separate sheet to write anything else you feel may be important.						
Trease use this space of a separate sheet to write anything else you reel may be important.						
Thank you for takin	g the time	e to reflect on a	II the issues that may	be impinging on vo	ur health. Each of us has	.
responsibility for our own health and, as a medical herbalist, I will endeavour to help you achieve your optimum						
sense of wellbeing.	If your p	resenting probl	em is beyond my sco	pe of practice, I will	tell you, and will suggest	:/refer
you to the appropriate practitioner.						
Signed			Date			