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

CONFIDENTIAL HEALTH AND LIFESTYLE INTAKE FORM

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Dear Patient:

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.

Thank you.

PT#: ________

WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER? YES or NO. Please circle your choice.

PATIENT INFORMATION

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:

MOTHER ________________________________ FATHER ___________________________

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 has most helped your allergies?

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

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ARE YOU CURRENTLY SEEING ANY OTHER HEALTH CARE PROFESSIONALS? YES _______ 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 problems	Headaches	Hearing problems
Heart disease	Hepatitis A, B, or C	High blood pressure	HIV
Hyperglycaemia	Hypoglycaemia	Immune disorders	_Injuries
Low blood pressure	Male health problems	Memory loss	Menopause problems
Menstrual irregularities	Numbness	Painful joints	Rashes
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, mental illness, asthma, hay fever, eczema, anaemia, glaucoma, kidney disease, etc. (if deceased, age at death and cause of death)

Father ____

Mother ____

Siblings____

GENERAL HEALTH ENERGY LEVELS

Are you satisfied with your current energy levels? If not, please describe:

____

Have your energy levels changed markedly at any point recently or in your past. What preceded this change?

____

BODY TEMPERATURE Please write 'H' for Hot and 'C' for Cold, if applicable to these body areas:

Arms	Hands	Palms
Fingers	Legs	Feet
Genital region	Head	Chest
Stomach	General body	

Other:

Using a scale of 1 (least favourite/strong aversion) to 5 (favourite), check off these weather conditions:

Hot ____ Very hot ____ Cold ____ Very cold ____ Damp ____ Dry ____ Humid____

EMOTIONAL

Use a scale of 1 (rare) to 5 (very common) on the below conditions if they are pertinent to you.

Angry	Anxious	Attentive	Bi-polar	Depressed
Dreamy	Enthusiastic	Fearful	Forgetful	Grumpy
Happy	Inspired	Lethargic	Manic	Nervous

Pessimistic	Sad	Worry a lot		

Other____________________

How would you describe your emotional health generally? I.E good, ok, poor, don't think about it, not relevant (Please circle your choice).

How would you describe your spiritual health? ? I.E good, ok, poor, don't think about it, not relevant (Please circle your choice).

MEMORY AND CONCENTRATION

How is your long-term and short-term memory?

Has your memory changed noticeably in the past few years?

How is your concentration?

Has it changed? If so, when and in what way?

HEADACHES

Do you ever have headaches? If so, please give as much detail as possible.

How often?

How long have you had them?

Location/type of headaches?

What triggers them?

Other symptoms associated with the headache (i.e., stomach pain)?

Are they more or less often than in the past?

Does the severity or intensity vary from episode to episode?

What medicines and treatments have you tried, which were most successful?

____

Please check if the following apply:

After eating	Afternoon	Around eyes	Around temples	Aversion to stimuli
Back of head	Band around head	Before eating	Chronic	Cluster
Constant	Dull	Evening	Front of head	Left side
Migraine	Morning	Night	Pounding	Pre-menstrual
Right side				

Other____

SLEEP PATTERNS On a scale from 1 (rarely) to 5 (very often) mark the conditions pertinent to you.

Fall asleep fast	Hard to fall and stay asleep	Restless sleep
Sleep through the night	Wake often	Restful sleep
Hard to fall asleep, but stay asleep	Wake up to urinate	Hard to wake up
Bed before 11:00 pm	Bed before 1:00 am	Up until 3.00 am

Other____

Which are your favourite hours to sleep? _________________

Generally, how many hours of sleep do you need to feel rested?______________________

Do you feel rested when you wake in the morning?________________________________

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
Any other problems with skin, hair or nails?			

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 smell	
Other			

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	_Ischemia
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, environmental factors or situations that worsen your breathing? Yes or No

If so, what are they?____

Mucous (tick the symptoms which pertain to you)

Is mucous currently a problem? Yes____ No ____

What is the quality and/or colour of the mucous:

____Clear ____Green ____Yellow ____Thick/sticky ____Thin/runny

Is it worse in the morning, afternoon, evening, and/or night (circle)

Do you have much congestion? ________ yes _________no

Which season is it worse and best? ________________________

What helps it?___________

Cough (check the symptoms which pertain 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 wake 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 still have urine in your bladder?___________________

Have you had urinary tract infections? _________ How often? __________________

GASTRO-INTESTINAL

Digestion: 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 movements 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	

Special diets; current and/or previous____

What are your favourite and least favourite foods?____

How much do you drink everyday? What do you drink?____

What did you have for breakfast, lunch, and dinner yesterday?

NERVOUS SYSTEM AND STRESS

Please mark with '**P'** for previously and '**C'** currently to any conditions that are pertinent to you.

Please also follow a scale of **1** (noticeable but not a big problem) to **5** (major problem).

Anxiousness	Bipolar	Butterflies in stomach
Cannot stay asleep	Constant feeling of stress	Diminished taste
Depression	Fear of facing a new day ____	Fluctuating vision
Hard to concentrate	Involuntary spasms	Mania
Memory loss	Nervousness	Numbness
Pain – constant	Panic attacks	Seasonal affective disorder
Sudden mood swings	Trouble falling asleep	Twitching
Worsening coordination/balance		low energy
Seizures	irritable	foggy/spacey feeling
Other		

Describe your stress levels on a scale of '1' (not stressed) to '10' (really stressed).______________________________

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

____

<u>REPRODUCTIVE</u> – 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 (HPV)	Other	

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 so, how often?	Does your prostate region ever hurt?	If yes, is pain dull, constant, throbbing or sharp?__
Is it ever painful to urinate? If so, describe the pain		
Does the urge to urinate interfere with your daily activities?		

REPRODUCTIVE – FEMALE

Pregnancy Are you pregnant? If so, how many months? _______________

Are you trying to become pregnant? If so, how long have you been trying? _____________

Number of pregnancies ______ number of births ______ Premature births ______ miscarriages ______

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

General

Breast pain	Cervical dysplasia	Cysts
Endometriosis	Fibroids	Infertility
Miscarriage	Painful intercourse	Pelvic inflammatory disease (PID)
STDs	Tumours	_Unusual PAP
Vaginal discharge	Vaginal dryness	Vaginal infection
Vaginitis	**Other**	

Menstrual Cycle

Acne	Bleeding between cycles	Mood swings
Bloating (hands, stomach)	Bloating (feet, hands, ankles)	Irregular cycle
Painful menses	mid cycle discomfort, bloating, pressure?	
PMS-if yes, describe symptoms:		
Age at first period	Average number of days bleeding:	Approximately how many days between periods?
Is it regular or irregular?		

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	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.

Thank you for taking the time to reflect on all the issues that may be impinging on your 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 presenting problem is beyond my scope of practice, I will tell you, and will suggest/refer you to the appropriate practitioner.

Signed____ Date________________