VERVAIN

C 416.707.1221
Email: carmen@vervain.ca
Website: vervain.ca

Consultation Date _____

CONFIDENTIAL HEALTH INTAKE FORM
The purpose of this intake is to inform me of the condition(s) you are currently presenting with, as well as clear and concise information of your past and present health including all body systems. Please be thorough, accurate and clear as this will assist me in providing the most effective care. If you would rather discuss information in person, please feel free to make a note. This form is ideally completed by patient and submitted to me prior to the appointment via fax or email, for me to preview. Please bring with you any medical records i.e. blood work/lab results, pathology reports that I may review at the time of appointment.

Name of patient _____
Age _____ Birth date _____
Address _____
City _____ Province/State _____
Postal code/zip code _____
Home phone # _____ Cel _____
Email: _____
Height _____ Weight _____

Employment status ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed
Occupation _____ How long? _____

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Emergency contact _____ Phone # _____
Relationship to patient _____

What are the major health concerns that brought you to this office today?
_____
_____
When did the condition begin? _____
Has anything changed or become worse? _____

SUPPLEMENTS/MEDICATIONS/HERBS/VITAMINS CURRENTLY USING:

Herb/Supplement	Brand name	Potency (mg, IU)	Dose	Frequency

Medication name	What it's for	Frequency	For how long	Strength/dose

Are you currently seeing any other health care professional? If so, please provide name and title.
_____

DO YOU:
Smoke cigarettes? _____How many? _____ How often? _____
Do you consume alcohol? _____ How much? _____ How often? _____
Do you drink coffee? _____ How much? _____ How often? _____
Do you use recreational drugs? _____ What substance? _____ How often? _____
Do you exercise? _____ What type? _____ How often? _____

ALLERGIES/SENSITIVITIES
Allergies to drugs? If so, what drugs? _____
Allergies to foods, pollen, pets, etc _____
Have you been exposed to radiation, toxic chemicals, heavy metals, pesticides beyond those encountered in daily life? _____

VACCINATIONS
(Please include dates where possible)

☐ Flu shot _____ ☐ Measles/Mumps/Rubella _____

☐ Tetanus/Whooping cough/Diptheria _____

☐ Polio _____

☐ Other _____

PAST MEDICAL HISTORY
Did you have any of the following childhood illness?

☐ Measles	☐ German measles (Rubella)	☐ Tonsillitis
☐ Chicken pox	☐ Psoriasis	☐ Ear infections
☐ Scarlet fever	☐ Bronchitis	☐ Asthma
☐ Mumps	☐ Mononucleosis	☐ Allergies
☐ Atopic eczema	☐ Whooping cough (Pertussis)	☐ Meningitis
☐ Pneumonia	☐ Tuberculosis	☐ Urinary tract infections
☐ Polio	☐ Other _____	

Were you born natural birth? _____ Were you breastfed? _____
Have you ever been diagnosed with Cancer? _____
If so, what type? _____ When? _____
Did you receive radiation treatment/chemotherapy? _____

HOSPITALIZATIONS/SURGERY/ACCIDENTS

Date	Doctor	Diagnosis/Surgery/Nature of accident

DIET

Dietary preferences/restrictions/sensitivities _____
What is your favourite food? _____ Favourite flavour? _____
What does your typical diet consist of, for:
Breakfast _____
_____
Lunch _____
_____
Dinner _____
_____
Snacks _____
_____
Fluids _____
_____

FAMILY MEDICAL HISTORY

Please include any conditions such as high blood pressure, coronary artery disease, stroke, diabetes, thyroid or renal disease, cancer (specify type), arthritis, tuberculosis, asthma or lung disease, headache, seizure, mental illness, suicide, alcohol or drug addiction, allergies, or other

Member	Alive?	Age	Diseases	Cause of Death	Age at death
Mother					
Father					
Brother(s)					
Sister(s)					
Mom's mother					
Mom's father					
Dad's mother					
Dad's father					
Mom's siblings					
Dad's siblings					

REVIEW OF SYSTEMS

Have you experienced any of the following **in the past 3 months**?

☐ Fatigue ☐ Night sweats ☐ Slowed metabolism (easy weight gain)

☐ Fever ☐ Excessive thirst ☐ Intolerance to heat or cold

☐ Chills ☐ Sudden energy drops ☐ Weight loss

PLEASE CHECK THE BOX BESIDE THE CONDITION(S) YOU HAVE OR HAVE HAD. PLEASE WRITE "C" FOR CURRENT OR "P" FOR PAST

SKIN & HAIR

☐ Rashes ☐ Recent moles ☐ Recent change in moles ☐ Brittle cracking nails
☐ Acne ☐ Lumps ☐ Pigment change ☐ Lines/marks on nails
☐ Eczema ☐ Boils ☐ Hair loss
☐ Psoriasis ☐ Poor healing wounds ☐ Dry hair
☐ Hives ☐ Impetigo ☐ Dandruff
☐ Itching ☐ Skin tags ☐ Oily hair
☐ Dry skin ☐ Other, explain: _____

HEAD, EYES, EARS, NOSE, MOUTH & THROAT

☐ Headache ☐ Eye pain ☐ Grinding teeth
☐ Dizziness ☐ Spots in front of eyes ☐ Vertigo
☐ Light-headedness ☐ Excessive tearing ☐ Earaches
☐ Clicking jaw ☐ Ear infections ☐ Discharge from ears
☐ Facial pain ☐ Hearing loss ☐ Frequent colds
☐ Glasses or contact lenses? ☐ Hay fever
☐ Blurred vision ☐ Ringing in ears ☐ Mucous in throat
☐ Cataracts ☐ Sinus congestion ☐ Swollen glands
☐ Glaucoma ☐ Nose bleeds ☐ Canker sores
☐ Cold sores ☐ Difficulty swallowing ☐ Loose teeth
☐ Changes in sense of smell ☐ Other, explain: _____

BREASTS

☐ Lumps ☐ Discomfort ☐ Do you do self-examination practices?
☐ Pain ☐ Nipple discharge ☐ Other, explain: _____

RESPIRATORY

☐ Cough ☐ Flu (influenza) ☐ Emphysema ☐ Pain when breathing
☐ Bronchitis ☐ Wheezing ☐ Tuberculosis ☐ Difficulty breathing in
☐ Pneumonia ☐ Laryngitis ☐ Coughing up blood
☐ Asthma ☐ Pleurisy ☐ Shortness of breath without exertion
☐ Difficulty breathing when lying down ☐ Other, explain: _____
☐ Production of phlegm? If yes, what colour/consistency?
☐ Clear ☐ Thick, sticky ☐ Yellow ☐ Thin, runny ☐ Green ☐ Bloody
If you have cough, please explain the character by checking the appropriate boxes:
☐ Dry cough ☐ Persistent ☐ Itchy throat

☐ Wet cough ☐ Hacking ☐ Productive
☐ Painful ☐ Whooping ☐ Unproductive

CARDIOVASCULAR, HEART & CIRCULATION

☐ High blood pressure ☐ Low blood pressure ☐ Blood clots
☐ Heart murmurs ☐ Varicose veins ☐ Phlebitis
☐ Chest pain/discomfort ☐ Broken blood vessels ☐ Fainting
☐ Palpitations ☐ Cold hands & feet ☐ Pins and needles
☐ Shortness of breath ☐ Swelling of hands ☐ Bleed easily
☐ Bruise easily ☐ Swelling of feet ☐ Stroke
☐ Rheumatic fever ☐ Pain/cramping in legs when walking
☐ Congestive heart failure ☐ Other, explain: _____

DIGESTION

☐ Difficulty swallowing ☐ Poor appetite ☐ Anorexia nervosa ☐ Gas
☐ Indigestion ☐ Bad breath ☐ Bulimia ☐ Large appetite
☐ Nausea ☐ Abdominal pain ☐ Crohn's disease ☐ Food cravings
☐ Constipation ☐ Bloating ☐ Dysentery ☐ Rectal pain
☐ Diarrhea ☐ Fatigue after eating ☐ Ulcer ☐ Gallstones
☐ Hemorrhoids ☐ Food allergies ☐ Vomiting ☐ Change in bowel habit
☐ Food intolerance ☐ Hepatitis ☐ Jaundice
☐ Other, explain: _____

BOWEL MOVEMENTS

Please check box(es) which pertain to you

☐ Blood in stools ☐ Oily/shiny stool ☐ Hard/compacted stool
☐ Mucus in stools ☐ Loose stool ☐ Oily film in toilet bowl
☐ Black stool ☐ Floating stool ☐ Fowl odour
☐ Blood on toilet paper ☐ White/light grey stool ☐ Other _____

Number of bowel movements per day _____
Do you rely on enema, laxative, purgative for bowel elimination? _____

URINARY

☐ Frequent urination ☐ Kidney stones ☐ Strong-smelling urine
☐ Burning or pain on urinating ☐ Irregular flow ☐ Lower back pain
☐ Blood in urine ☐ Decrease in flow ☐ Water retention
☐ Urinary tract infection ☐ Difficulty stopping or starting the flow or urine
☐ Dribbling ☐ Other, explain: _____

MUSCULOSKELETAL

☐ Muscle pain ☐ Neck pain

☐ Muscle weakness ☐ Limitation of motion or activity

☐ Joint pain ☐ Arthritis

☐ Stiffness ☐ Gout

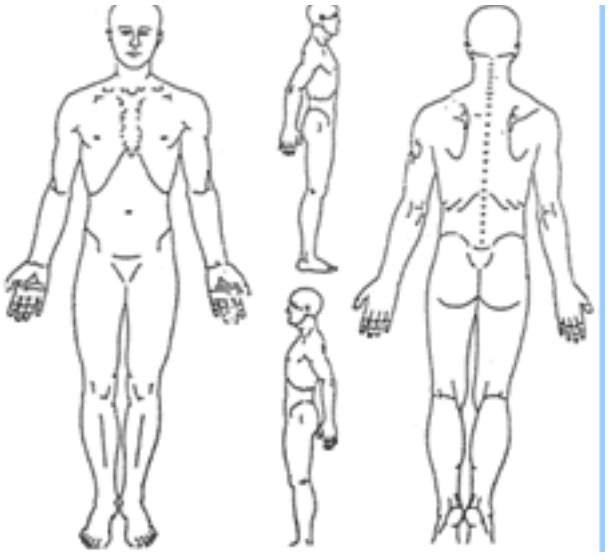
☐ Involuntary muscle spasms

☐ Back pain ☐ Other, explain: _____

Is the pain worse at morning or evening?_____

Chiropractic, or massage therapy? _____ How often? _____

Please indicate painful areas and rate pain of each area on a scale of 1 to 10 (10 being severe pain)
Write comments to the right if you wish.



NEUROPSYCHOLOGICAL

☐ Anxiety	☐ Memory loss	☐ Tingling or pins and needles
☐ Mood swings	☐ Dizziness	☐ Irritability
☐ Depression	☐ Vertigo	☐ Migraine
☐ Poor sleep	☐ High stress levels	☐ Difficulty concentrating
☐ Poor memory	☐ Seizures	☐ Foggy or spaced-out feeling
☐ Headaches	☐ Blackouts	☐ Chronic pain
☐ Numbness	☐ Paralysis	☐ Disoriented
☐ Lack of balance	☐ Panic attacks	☐ Lack of energy
☐ Feel like crying a lot	☐ Bored	☐ Lonely
☐ Happy	☐ Forgetful	☐ Inspired

How is your short-term memory? _____

How is your long-term memory? _____
How is your concentration? _____
Have you noticed any changes in these in the past year? _____
How would you rate your daily stress levels from 1 to 10?
(1 being relaxed and 10 being high stress) _____
How many hours of sleep per 24 hours _____Naps? _____
Stress management techniques? _____

REPRODUCTIVE – MALE
Please check the boxes applicable to you and write "p" for past condition or "c" for current condition

☐ Hernia ☐ AIDS ☐ Painful ejaculation
☐ Discharge from penis ☐ Candida ☐ Blood in semen
☐ HIV ☐ Genital warts ☐ Premature ejaculation
☐ Sores on penis ☐ Urethritis ☐ Erectile dysfunction
☐ Testicular pain or masses ☐ Benign prostatic hypertrophy (BPH)
☐ Scrotal pain or swelling ☐ Excessive sexual thoughts
☐ Impotence ☐ Low libido ☐ Low vitality

☐ Sexually transmitted diseases, please explain: _____
Do you ever have difficulty getting and/or maintaining an erection? _____

***MALES PLEASE SKIP TO BOTTOM OF PAGE 8 TO SIGN FORM BEFORE IT'S COMPLETED**

REPRODUCTIVE - FEMALE
Please check the boxes applicable to you and mark "c" for current and "p" for past

☐ HIV ☐ Breast pain ☐ Herpes
☐ Candida ☐ Breast lump ☐ Hysterectomy
☐ AIDS ☐ Endometriosis ☐ D & C
☐ Pelvic Inflammatory Disease ☐ Miscarriage ☐ Interstitial cystitis
☐ Irregular PAP ☐ Fibroids ☐ Pain with intercourse
☐ Mastectomy ☐ Tubal ligation ☐ Yeast infections
☐ Dryness with intercourse ☐ Lumpectomy ☐ Polycystic Ovarian Disease
☐ Infertility ☐ Cysts

☐ Sexually transmitted disease? Explain: _____

☐ Vaginal discharge? Colour _____ Frequency _____ Amount _____

MENSTRUAL PERIODS
Please complete the following section to your best ability even if you no longer menstruate as it provides valuable information for an accurate assessment.
Age at first period _____ Length of cycle _____ Average # of days bleeding _____

☐ Menstrual cramps? On which days? _____

☐ Light flow ☐ Heavy flow ☐ Clots?

Colour of blood: ☐ Bright red ☐ Red brown ☐ Mucus

☐ PMS ☐ Bloating ☐ Spotting between periods ☐ Mood swings

☐ Acne ☐ Irritability ☐ Food cravings. Explain: _____

Date of last menses _____
Are you pregnant now? _____
Number of pregnancies _____ Number of children _____
Are you breastfeeding? _____

☐ Terminations ☐ Miscarriages ☐ Tubular pregnancies

☐ Difficulty in conceiving
Do you currently use birth control? _____ Type _____

MENOPAUSE
No menses since _____

☐ Dry vaginal mucosa ☐ Hot flashes ☐ Postmenopausal bleeding

☐ Mood swings ☐ Palpitations ☐ Hormone replacement therapy

☐ Osteoporosis ☐ Night sweats ☐ Fatigue

☐ Dry skin & hair ☐ Joint & limb pain ☐ Insomnia

☐ Headache/migraine ☐ Depression ☐ Poor memory

How did you hear of Carmen Lynde or the Vervain clinic?
_____
_____

WAIVER OF LIABILITY AND CANCELLATION AGREEMENT

HOLISTIC NUTRITIONIST, CLINICAL HERBALIST: CARMEN LYNDE, CNP, CHT, RH

I, the undersigned hereby confirm that I understand that the above named individual is not a medical doctor nor is she licensed to practice medicine. I affirm that I am consulting with this practitioner for educational purposes and of my own free will. I understand there will be no diagnosis made, nor prescription given, but that the practitioner will offer an assessment of my general state of health and will make dietary and botanical recommendations.
I understand that fees are payable at the time of the appointment by the patient. I understand that full fees will be charged for missed appointments and for appointments cancelled with less than 24 hours notice.

_____ Date Signed _____
Signature of patient or guardian

_____
Print name of patient or guardian