VERVAIN

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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 ___________________
Height _______________ Weight _____________
Address ____
City __________________________ Province/State ______________________
Postal code/zip code _____________________
Home phone # ____________________________ Cel ____________________________
Email: ____
Name of parent/guardian ______________________________
Relationship to patient _______________________________________
Phone # (if different from above) ________________________

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.

____

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

__ Flu shot __ Measles/Mumps/Rubella

__ Tetanus/Whooping cough/Diptheria

__ Polio

__ Other ______________________________

PAST MEDICAL HISTORY

__ 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 ____

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 favorite food? _______________________ Favorite flavor? ____________________
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	Living ?	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					

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 __ Grinding teeth __ Dizziness __ Earaches
__ Light-headedness __ Tonsillitis __ Clicking jaw __ Ear infections
__ Facial pain __ Frequent colds __ Glasses or contact lenses? __ Hay fever
__ Blurred vision __ Mucous in throat __ Sinus congestion __ Swollen glands
__ Nose bleeds __ Canker sores __ Cold sores __ Difficulty swallowing
__ Other, explain: ____

RESPIRATORY

__ Cough __ Flu (influenza) __ Bronchitis __ Wheezing
__ Pneumonia __ Asthma __ Whooping cough __ Croup

CARDIOVASCULAR, HEART & CIRCULATION

__ High blood pressure __ Low blood pressure __ Heart murmurs
__ Palpitations __ Cold hands & feet __ Bruise easily

DIGESTION

__ Colic __ Poor appetite __ Gas
__ Indigestion __ Bad breath __ Nausea __ Abdominal pain
__ Constipation __ Diarrhea __ Food allergies __ Vomiting
__ Change in bowel habit __ Food intolerance

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 odor
__ 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 __Burning or pain on urinating __ Blood in urine
__Urinary tract infection __Other, explain: _____________________________________

MUSCULOSKELETAL

__ Muscle pain __ Muscle weakness __ Limitation of motion or activity
__ Joint pain __Other, explain: ____

NEUROPSYCHOLOGICAL

__ Anxiety __Mood swings __Dizziness
__ Depression __ Poor sleep __ Difficulty concentrating
__Seizures __ Headaches __Lack of energy
How many hours of sleep per 24 hours ________ Naps? ________

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

____
____

WAIVER OF LIABILITY AND CANCELLATION AGREEMENT
MEDICAL HERBALIST: CARMEN LYNDE, 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 herbal 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.

____
Signature of patient or guardian

____
Print name of patient or guardian

____
Date signed