Sacred Waters Healing Circle

Herbal Medicine Clinic - New Client Questionnaire

Please answer the questions below. Your answers assist in determining the best possible clinical assessment. Please allow 30 minutes to complete this questionnaire.

Today's Date __________________

Name___________________________________

Address____

Telephone Day___________________ Night____________________ E mail:_________________________________

Emergency Contact: ____________________________ Best way to contact you:________________________________

Date of Birth _________ Age_____ Place of Birth____

Where and when have you lived or traveled outside the U.S. and Canada? ____________________________________

____

Education: ______________________________________

Passions/Interests: ___________________________________

Occupation _____________________________ How long_______________

Relationship Status: _______________________

What are your primary reasons for coming to the clinic?

1.____

2.____

3.____

What other health-related issues do you have/have you had in the past?

Are you currently working with any other health care practitioners? ________

Family

Relationship	***Alive/Deceased***	***Present health or cause of death***
Father	_____________	____
Mother	_____________	____
Brothers	_____________	____
Sisters	_____________	____
Children/ages	_____________	____
	_____________	____

Have you or any blood relatives had any of the following? (Circle those that apply to family members, check those that apply to you)

☐ Allergy/Asthma	☐ Headaches/Migraines	☐ Stroke
☐ Arthritis	☐ Heart Disease	☐ Substance abuse
☐ Bleeding/Clotting Tendency	☐ High Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Kidney Disease	☐ Tuberculosis
☐ Diabetes	☐ Obesity	Other

DIET

Please check boxes & indicate how often you use the following (daily, weekly, monthly, etc)

❍ Dairy products	❍ Soy products	❍ Fruits
❍ Soft drinks	❍ Fish	❍ Alcohol
❍ Margarine	❍ Bakery goods	❍ Red Meat
❍ Butter	❍ Nuts & Seeds	❍ Fried foods
❍ Coffee	❍ Vegetables	❍ Water
❍ Tobacco	❍ “junk food” type:	

How often do you eat at restaurants? ________________ How often do you cook/prepare food? ________________

How many meals do you eat a day? _________________ How often do you snack & when? _____________________

What foods do you crave? ____

Are you allergic or sensitive to any substances? ____

Have you had lengthy exposure to environmental toxins?____

Do you follow or have you ever followed a restricted diet? Which one(s)? ___________________________________

Please indicate an example of (1) your diet when have time and energy to prepare meals and (2) a typical diet when stressed or pressed for time. Please include beverages.

(1): Breakfast	Lunch	Dinner	Snack (time of day)
(2): Breakfast	**Lunch**	**Dinner**	**Snack (Time of day)**

Supplements & Medications

Medications currently or previously used (Over the counter and prescription)

Name	Dosage / Frequency/Duration	For what reason are you taking this?

Supplements/vitamins/herbs currently used

Name	Dosage / Frequency/Duration	For what reason are you taking this?

General Health Questions

Highest weight as an adult: ______ Year: _____ Lowest weight as an adult: ______ Year: ________
Are you satisfied with your energy levels? Yes Sometimes No
Do you have regular bowel movements? Yes No
How many bowel movements do you have per day? _________ Per week? ___________
Is it ever difficult to move your bowels?_______________

Typical hours spent watching TV per day ________ Typical hours on the computer per day ____________________
Exercise –type/frequency/for how long____
____
Typical bedtime __________________ Typical hours asleep _________
Do you feel rested upon waking? __________________________________
Are you satisfied with your primary relationship and/or your support system?____________________________________
On a scale from 1 (low) to 10 (high), how stressful is your: Work?_____ Health status?______ Social/family situation?___
What would you describe as the dominant emotions in your life right now?

Please list major events in the last ten years of your life and the dates they occurred (include births, deaths, marriages, divorce, accidents, moves, jobs changes, miscarriages, illness and anything else you feel greatly impacted your life)
Date **Event**

Additional things you'd like to mention related to health and well-being: