Name:

Date:

# Wellness Intake Form

Note: Information provided on this form and in all therapies will be held in strict confidence.

## I. Personal Information

Name_____

Age _____ Birthday_____Sex _____ Height_____Weight _____

Eye Color _____Phone Number _____Email_____

Occupation_____Other Primary Interest/Passions_____

Relationship Status_____

Anything you would like to share about your religious &/or spiritual beliefs_____

_____

## II. Diet, Nutrition and General Health Practices

A. Please explain your diet and a typical day of meals and snacks in the present season. Please also include any strong food aversions and/or typical flavor cravings (example: sweet, salty, spicy, etc)

B. How much water do you drink each day? _____ cups. Do you drink caffeine? What and how often?

C. How much sleep do you get each night on the average? _____ hours. How do you sleep?

D. How often do you exercise? _____ hours per _____ . What do you do for exercise?

E. What is your energy level like?

F. How often do you have bowel movements?

G. Are you pregnant or nursing a baby?

H. Do you feel like you are under stress? If so, explain.

I. What herbs and nutritional supplements are you currently taking?

J. What are current health concerns are you seeking help for? What is the primary concern?

K. What medications, medical procedures, supplements or therapies have you previously tried for your primary condition? Were any of these supplements or therapies helpful? If so, please note which ones were helpful.

## III. Medical Information

A. Are you under a medical doctor's care for your condition? _____ If so, what are you being treated for?

B. Are you currently taking any prescription or over-the-counter drugs? If so, please list each drug and what it is for.

C. Family History: Has anyone in your immediate family had any of the following?

| | | |
|---|---|---|
| ___Cancer | ___High blood pressure | ___Diabetes |
| ___Heart disease | ___Low blood pressure | Other_____ |

D. What serious injuries have you had? What therapies and/or drugs did you take for them?

E. Name any circumstances in which you were hospitalized along with approximate date and duration of stay.

F. Please list any surgeries you have had along with approximate date.

G. Have you been diagnosed by a licensed physician with any of the following? Circle all that apply.

| | | | |
|---|---|---|---|
| AIDS | Bipolar | Diabetes | Kidney Stones |
| Anemia | Bleeding Disorders | Eczema | Irritable Bowel Disorder |
| Angina | Cancer, Specify | Endometriosis | Lupus |
| Rheumatoid Arthritis | Celiac Disease | Epilepsy | Multiple Sclerosis |
| Osteoarthritis | Heart Attack | Fatty Liver Disease | Osteoporosis |
| Arrhythmia | Cirrhosis of the Liver | Fibromyalgia | Obsessive Compulsive Disorder |
| Asthma | Colitis | Hepatitis | Psoriasis |
| Autoimmune Disorders, Specify | Chronic Obstructive Pulmonary Disorder | Hashimoto's Disease (Thyroiditis) | Low Thyroid (Hypothyroid) |
| ADD/ADHD | Depression | High Blood Pressure | Ulcers |
| Benign Prostatic Hyperplasia (BPH) | Congestive Heart Failure | Graves Disease (Hyperthyroid) | Other, Specify |

## IV Specific Symptoms: Put “C” if it is a current symptom. Put "P" if it is a past symptom.

A. Digestive, Liver and Intestinal Symptoms

| | | |
|---|---|---|
| __Abdominal pain or discomfort, specify location | ___Food sits heavy on stomach after meals | ___Loss of appetite or poor appetite |
| ___Acid indigestion, heartburn or acid reflux | ___Food allergies, specify foods that give you problems: | ___Mucus in stools |
| ___Bad breath | ___Diarrhea or loose stools | ___Loss of smell or taste |
| ___Bloating, belching or intestinal gas | ___Groggy feeling in the morning | ___Underweight or unable to gain weight |
| ___Constipation | ___Hard, dry stools | ___Stomachache |
| ___Cravings for sugary foods | ___Hemorrhoids or anal fistula | ___Undigested food in stools |

B. Respiratory System Symptoms

| | | |
|---|---|---|
| ___Chronic or frequent cough | ___Frequent infections | ___Post nasal drip |
| ___Cold sores | ___Hay fever/respiratory allergies | ___Sinusitis or chronic sinus congestion, with headache? |
| ___Excess mucus production | ___Itchy nose or ears | ___Wheezing or shortness of breath |

C. Circulatory System Symptoms

| | | |
|---|---|---|
| ___High blood pressure, specify numbers if known: | ___Low blood pressure, specify numbers if known: | ___Irregular heart-beat (arrhythmia) |
| ___Chest pain | ___Anemia | ___Rapid heart-beat |
| ___Cold hands and feet | ___Heart Palpitations | ___Gingivitis or gum disease |
| ___Family history of heart disease | ___High cholesterol, specify: | ___High triglycerides, specify: |
| ___Slow healing in extremities | ___Swelling in lower extremities | ___Varicose veins or spider veins |

D. Urinary and Fluid System Symptoms

| | | |
|---|---|---|
| ___Bladder infections/UTIs | ___History of kidney stones | ___Frequent, pale urine |
| ___Blood in the urine | ___Pain in mid to low back | ___Scant, dark urine |
| ___Excessive perspiration | ___Night sweats | ___Water retention (edema) |
| ___Frequent urination | ___Puffiness under eyes | ___Swollen lymph nodes |
| ___Burning or painful urination | ___Difficulty starting urination | ___Urinary incontinence (dribbling) |

E. Glandular System Symptoms

| | | |
|---|---|---|
| ___Burning sensations in hands and feet | __Feeling chronically stressed | ___Chronic or excessive fatigue |
| ___Cold hands and feet | ___Lack of stamina | ___Afternoon fatigue |
| ___Dark circles under eyes | ___Frequent thirst | ___Mood swings |
| ___Dry skin | ___Hair loss or thinning | ___Restless disturbed sleep |
| ___Excess weight around abdomen | ___Loss of short-term memory | ___Feeling exhausted, “burned out” |
| ___Low body temperature, easily chilled | ___ Mental sluggishness, “brain fog” | ___Muddled thinking, confusion |
| ___Restless dreams or nightmares | ___Waking up at night unable to go back to sleep | ___Waking up frequently at night |

*Females Only

| | | |
|---|---|---|
| __Cravings for chocolate with menstrual periods | ___Heavy menstrual bleeding | ___PMS |
| ___Depression with periods | ___Irritability with periods | ___Pregnant (currently) |
| ___Edema or bloating associated with periods | ___Painful menstruation/ cramps | ___Nursing (currently) |
| ___Hot flashes &/or night sweats | ___Vaginal discharge | ___Lack of sexual desire |
| ___Post-menopausal | ___Vaginal dryness | ___Infertility |

*Males Only

| | | |
|---|---|---|
| ___Difficult urination | ___Erectile dysfunction | ___Lack of sex drive |
| ___Urinating at night | ___Infertility | ___Prostate problems |

F. Nervous System Symptoms

| | | |
|---|---|---|
| ___Absent-mindedness or poor concentration | ___Difficulty getting to sleep | ___Loss of memory |
| ___Alcoholism | ___Dizzy or light-headed | ___Panic attacks |
| ___Anxiety, nervousness | ___Excitability, difficulty relaxing | ___Peripheral neuropathy |
| ___Chronic muscle tension | ___Feeling depressed or discouraged | ___Shaky hands |

Do you experience headaches?___ If so, how would you describe them? Frequency? Typical duration?

| |
|---|
| ___Tension headaches with tight, constricted feeling |
| ___Pounding headaches (like head is exploding) |
| ___Headaches around eyes or forehead |
| ___Migraines |

G. Skin

| | | |
|---|---|---|
| ___Acne | ___Itching, skin | ___Rosacea |
| ___Eczema | ___Rashes | ___Dry, skin |

H. Musculoskeletal Symptoms

| | | |
|---|---|---|
| ___Arthritis | ___Legs cramps or pains | ___Joint pain |
| ___Back pain | ___Multiple root canals | ___Tense muscles |
| ___Brittle fingernails | ___Muscle cramps | ___Sore feet |
| ___Gout | ___Neck pain | ___Osteoporosis |
| ___Teeth grinding or clenching | ___Stiff, aching or painful muscles | ___Weak legs, knees or ankles |

NOTICE TO ALL CLIENTS & STUDENTS

The United States of America currently has no licensing policy in regards to Herbal Medicine, and as a clinical Herbalist and certified Acupressurist, Emily Rose is not a licensed Medical Doctor (M.D.). She does not prescribe drugs, issue a diagnosis, nor suggest cures.

Emily's purpose is to educate her clients and students as to healing by natural processes. She considers herbs and foods to be nutritional assets to health, and it is in this way that she offers her advice. Although Emily personally believes that herbs are a part of good health care, she makes no claims for their medicinal actions. Any information offered is done so on the basis of research, experience, and traditional uses.

All clients and students of Roots & Roses agree to make their own choices as to what they do with the educational material they have been offered and are solely responsible for their own decisions and actions. It is always suggested that the client/student seek out the advice of a licensed health-care practitioner whenever they feel it is necessary in regards to their own personal health.

I have read, understand, and agree with the above statement. My purpose in seeking the advice of Emily Rose is done so for educational and nutritional purposes only.

Signature: _____ Date:_____