



**Health History Intake Form**

PERSONAL INFORMATION

Name \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Address:

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Occupation \_\_\_\_\_

Marital status \_\_\_\_\_

Children (#/ages) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Note: this is a confidential record of your medical history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so in writing. Please complete the questionnaire as thoroughly as possible. Thank YOU!*

What are the major concerns that have brought you to seek an Herbal Consultation?

\_\_\_\_\_  
\_\_\_\_\_

When did this begin? \_\_\_\_\_

Has anything recently changed or become worse? \_\_\_\_\_

Have you had a diagnosis? If so, what was it, how was it arrived at, and by whom? \_\_\_\_\_

Are you currently receiving care from any other health professional?

Name: \_\_\_\_\_

What condition(s)? \_\_\_\_\_

Are you currently taking any medications, prescription or otherwise? YES \_\_\_\_ NO \_\_\_\_

Please list them: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Do you have any infectious diseases that you know of? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please list them: \_\_\_\_\_

Are you pregnant? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, how many months? \_\_\_\_\_ What is your anticipated delivery date: \_\_\_\_\_

Do you have any known allergies or sensitivities? If so, please list them:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any reason why you could not take remedies made in alcohol?  
\_\_\_\_\_

Have you ever been hospitalized or had any surgeries? If so, please note date and reason:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Please complete this section only for family members with particular health issues.

AGE (If deceased, age at death and cause) HEALTH PROBLEMS

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers/ \_\_\_\_\_

Sisters \_\_\_\_\_

Children \_\_\_\_\_

Other close  
blood relatives \_\_\_\_\_

**PERSONAL HEALTH / HABITS**

Height \_\_\_\_\_ Current weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many years? \_\_\_\_\_ Amount daily \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ What? \_\_\_\_\_ Frequency \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ What? \_\_\_\_\_ Frequency \_\_\_\_\_

Do you drink coffee \_\_\_\_\_ How many oz? \_\_\_\_\_ Tea? \_\_\_\_\_ How much \_\_\_\_\_



Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ Frequency? \_\_\_\_\_

Type of exercise? \_\_\_\_\_ Duration? \_\_\_\_\_

**HEALTH CONCERNS** Check off any experienced in the last three months

**SKIN & HAIR**

- Rashes
- Itching
- Dandruff
- Change in skin texture
- Eczema
- Hair Loss
- Other: \_\_\_\_\_
- Hives
- Pimples
- Moles
- Poor healing sores

**HEAD, EYES, EARS, NOSE & THROAT**

- Poor vision
- Earaches
- Ringing in the ears
- Cold sores
- Facial pain
- Sinus congestion
- Ear infections
- Spots in front of eyes
- Cataracts
- Blurred Vision
- Sore throat
- Grinding teeth
- Clicking jaw
- Mucous in throat
- Dizziness
- Other: \_\_\_\_\_
- Glaucoma
- Poor hearing
- Canker sores
- Nose bleeds
- Eye pain
- Swollen glands
- Frequent colds

**CARDIOVASCULAR**

- High Blood Pressure
- Irregular heart beat
- Cold hands or feet
- Low Blood Pressure
- Fainting
- Other: \_\_\_\_\_
- Chest pain
- Palpitations

**RESPIRATORY**

- Cough
- Coughing blood
- Shortness of breath without exertion
- Difficulty breathing when lying down
- Production of phlegm YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, what color? \_\_\_\_\_
- Other: \_\_\_\_\_
- Bronchitis
- Pneumonia
- Asthma
- Pain on breathing

**GASTROINTESTINAL**



- Nausea
- Constipation
- Abdominal pain
- Blood in stools
- Hemorrhoids
- Food cravings
- Difficulty swallowing
- Vomiting
- Black stools
- Indigestion
- Mucous in stools
- Gas
- Poor appetite
- Heartburn
- Rectal pain
- Bad breath
- Food allergies
- Other: \_\_\_\_\_
- Bloating
- Diarrhea

# of bowel movements daily \_\_\_\_\_ Loose Normal Hard

URINARY

- Painful urination
- Urinary urgency
- Incontinence
- Difficulty starting/stopping slow
- Other: \_\_\_\_\_
- Frequent urination
- Kidney stones
- Inability to hold urine
- Blood in urine
- Irregular flow
- Decreased flow

MUSCULOSKELETAL

- Neck pain
- Back pain
- Other: \_\_\_\_\_
- Muscle pain
- Muscle weakness
- Stiffness
- Reduced range of motion
- Do you see a chiropractor or massage therapist? Yes / No (name) \_\_\_\_\_

REPRODUCTIVE

- Age at first menses: \_\_\_\_\_
- Length of cycle: \_\_\_\_\_
- Duration of bleeding: \_\_\_\_\_
- Heavy bleeding
- Pain with intercourse
- Unusual bleeding
- Migraines Yes / No Duration/frequency: \_\_\_\_\_
- Cramps
- Discharges
- Irregular cycles
- Breast lumps
- Clots
- Color: Brown / Black / Bright Red

PMS? If yes, what symptoms and how long before cycle do they start? \_\_\_\_\_



Date and result of last pap smear \_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_ # of miscarriages \_\_\_\_\_ Premature births \_\_\_\_\_

Type of birth control used: \_\_\_\_\_

Any other gynecological problems? \_\_\_\_\_

NEUROPSYCHOLOGICAL

- Poor sleep
- Depression
- Seizures
- Headaches
- Lack of coordination
- Loss of balance
- Poor memory
- Irritability
- High stress levels
- Difficulty concentrating
- Other: \_\_\_\_\_
- Numbness
- Anxiety
- Migraine
- "Spacey" / foggy feeling

Hours of sleep per 24 hour day \_\_\_\_\_ When?: AM PM Shift work

GENERAL

- Fatigue
- Night sweats
- Slow metabolism
- Other: \_\_\_\_\_
- Fevers
- Excessive thirst
- Intolerance to heat/cold
- Chills
- Sudden energy drops

In addition to the above information, please include the following:

- 3-5 day diet diary, including snacks and water intake

- Supplements taken (both vitamins and herbal)

    Include name of supplement

    Manufacturer's name



Willow Moon Herbals

po box 147, schooley's mtn, nj 07870 201/650-7500 www.willowmoonherbals.com

how many mg/mcg/iu in each tablet/capsule

Dosage: how many YOU take per day

- Copies of any recent lab work (within one year)

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank *YOU!*