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

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	□ Eczema	□ Pimples
□ Itching	□ Hair Loss	□ Moles
□ Dandruff	□ Other:_____	
□ Change in skin texture	□ Hives	□ Poor healing sores

HEAD, EYES, EARS, NOSE & THROAT

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

CARDIOVASCULAR

□ High Blood Pressure	□ Low Blood Pressure	□ Chest pain
□ Irregular heart beat	□ Fainting	□ Palpitations
□ Cold hands or feet	□ Other:_____	

RESPIRATORY

□ Cough	□ Bronchitis	□ Asthma
□ Coughing blood	□ Pneumonia	□ Pain on breathing

□ Shortness of breath without exertion

□ Difficulty breathing when lying down

□ Production of phlegm YES ____ NO ____ If yes, what color? _____

□ Other: _____

GASTROINTESTINAL

□ Nausea □ Hemorrhoids □ Black stools
□ Constipation □ Food cravings □ Indigestion
□ Abdominal pain □ Difficulty swallowing □ Mucous in stools
□ Blood in stools □ Vomiting □ Gas

□ Poor appetite □ Bad breath □ Bloating
□ Heartburn □ Food allergies □ Diarrhea
□ Rectal pain □ Other:_____

# of bowel movements daily _____ Loose Normal Hard

URINARY

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

MUSCULOSKELETAL

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

REPRODUCTIVE

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

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	□ Loss of balance	□ Other: _____
□ Depression	□ Poor memory	□ Numbness
□ Seizures	□ Irritability	□ Anxiety
□ Headaches	□ High stress levels	□ Migraine
□ Lack of coordination	□ Difficulty concentrating	□ "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

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*!