Kenton Cobb, Herbalist
kenton@phytoamorous.com
267.606.0750

Name: Date:

DOB: Age:

Address: Email:

Telephone: Best times to call:

This intake form is designed to provide insight into your health and health history by looking at the whole of your body, mind, diet, habits, stressors, symptoms and so forth. Drawing on many aspects can evidence patterns and tendencies helpful in understanding the current illness from a holistic perspective. Thus, there are number of questions which may not seem pertinent to your current health concern. Despite this, please answer as much as you are able and are comfortable with, and mark anything you would rather speak about in-person. All information is held strictly confidential and will not be shared with anyone except with your release or request. Thank you!

What is your current gender identity? (circle all that apply)
Female   Male
Transgender Male/Transman/FTM   Genderqueer
Transgender Female/Transwoman/MTF   Additional category (please specify):
Decline to answer

What sex were you assigned at birth?
Male   Female   Decline to answer

What pronouns do you use/how can I refer to you?

What are the health concerns that you want to address?

Current health practitioner(s) you work with *(name, modality, any diagnoses):*

Current prescription *and* over-the-counter medications, herbs, or supplements

Med/Supp/Herb	Brand Name	Potency(mg/ iu)	Dose	Frequency	Duration	Helpful	Side Effects?
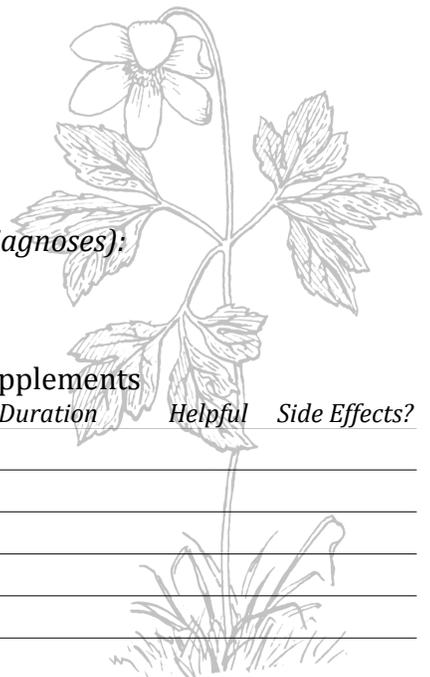
Dietary Summary

Outline a typical day. Include normal time ranges for meals and snacks.

Breakfast	
Lunch	
Dinner	
Snacks	

Discuss your eating schedule/habits (include snacks, etc):

Typical eating environment (at home, at work, sitting, standing, while driving, etc…):

How often do you prepare your own food?

Food cravings:

Food preferences (circle all that apply)
sweet   sour   salty   bitter   spicy   oily   cooked   raw

Known or suspected food allergies/intolerances/sensitivities:

What do you like about your dietary habits and what would you like to change?

Do you now follow or have you ever followed a special diet? Please describe and indicate when:

Daily water intake amount: Other fluids amount (eg. tea, coffee, juice, soda):

Frequency of consumption (how many servings/week)
____bread/pasta/wheat products/gluten ____coffee   ____fried foods
____soy products   ____sweets   ____eating out
____fast food   ____soda   ____fresh fruits
____dairy (eg. milk, cheese, yogurt,   ____fresh vegetables   ____animal protein

Medical and Family History:

Weight: Weight 1 year ago:

Height: Do you have siblings?   What order of birth are you?

For the following, please include dates and length of illness and recovery:
Major injuries/illnesses:

Surgical operations:

Other hospitalization:

Recent illness:

Childhood illness(es):

Do you smoke/chew tobacco?   How much?   How long?

Have you used tobacco in the past?   When?   How long?

Do you drink alcohol?   How much?   How often?

Do you use recreational drugs?   How much?   How often?

Please list any allergies to medications, chemicals, and environmental factors (pollen, dust, etc)

Please complete this section only for any family members with particular health problems.
          Age (if deceased age of death)   Health Problem
Father

Mother

Siblings

Children

Other

For the following, please check any that apply, and provide additional information as needed:

Digestive health

____ Poor appetite
____ Periodontal disease
____ Frequent burping
____ Heartburn
____ Gas
____ Intestinal pain/cramping
____ Incomplete digestion
____ Mouth frequently too dry
____ Indigestion after eating
____ Duodenal ulcer
____ Acid indigestion/reflux
____ Stomach ulcer
____ Bad breath in AM

____ Nausea
____ Cavities
____ Stomach pain/cramping
____ Acid reflux
____ Bloating
____ Frequent antibiotic use
____ Constipation
____ Diarrhea
____ Frequent burping
____ Bitter taste in AM
____ Oily stool
____ Often don't finish meals
____ Often eat to calm down

____ Blood in stool
____ Sometimes nausea in AM
____ Difficulty in swallowing
____ Sometimes nausea in PM
____ Mouth or cold sores
____ Butterflies in stomach
____ Strong Demanding hunger
____ Seldom eat breakfast
____ Frequent use of Alcohol
____ Constipation and diarrhea
     alternating

Frequency of bowel movements:

Quality of bowel movements (color/consistency):

Kidney and urinary system health

____Dull pain in lower back
____Kidney stones
____Yeast infection(s)
____Bladder control problems
____Painful urination
____Frequent thirst

____Swelling in hands/feet
____Urinary tract infection(s)
____Water retention
____Frequent urination
____Decreased urine flow

Frequency of urination: Quality of urine (color/odor):

Respiratory system health

____Nasal congestion (when?)
____Tenderness around eyes/back of neck
____Asthma
____Bronchitis (when?)
____Pneumonia (when?)
____Tuberculosis (when?)
____Frequent lung congestion

____Sinus infections
____Morning stuffiness
____Wheezing upon exertion
____Hoarseness/sore throat
____Shortness of breath
____Recurrent cough
____Hyperventilation

Mucus production in nose and/or lungs?   How often?

Color of mucus: Thickness:

Muscle/bone/joint health

____Cavities
____Osteoporosis
____Muscle pain
____Carpel tunnel
____Arthritis
____Torn ligaments/tendons/frequent sprains

____Brittle nails
____Broken bones
____Poor flexibility
____Tendonitis
____Chronic swelling/inflammation
____Joint stiffness

Results of bone density test (if applicable):
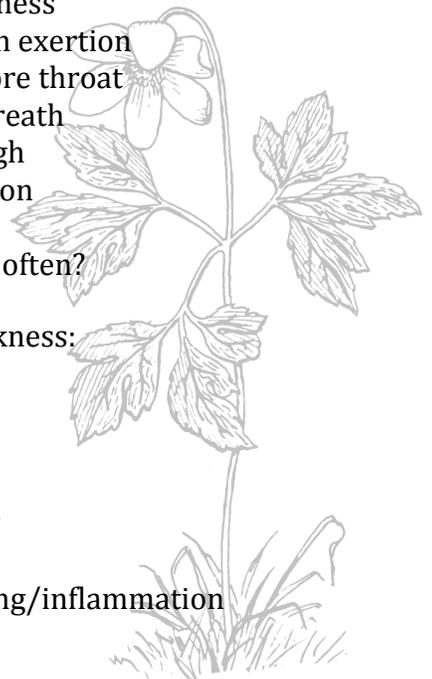
Energy reserves and stress:

____Fatigue   ____Easily tired
____Low energy in morning   ____Pain to touch
____Low energy in afternoon   ____Ongoing stressors
____Use relaxation techniques   ____Need coffee to get started
____Low energy in evening   ____Anemia
____Job stress   ____Family stress
____Debilitating disease   ____Current or past trauma

Favorite time of the day: Of year:

Exercise frequency, type, and duration:

Normal bedtime: Weekday: Weekend:
Normalwaking time: Weekday: Weekend:

Tell me about your sleep:

When you get sick/have problems, where/how does that typically happen?

Specific stressors right now:

How do you deal with stress?

Cardiovascular health

____High blood pressure   ____Heart attack
____Stroke   ____Congestive heart failure
____Atherosclerosis   ____Heart palpitation
____Arrythmia   ____Heart valve dysfunction
____Cold hands/feet   ____Numbness/tingling in fingers or toes
____Bruise easily   ____Sweat easily
____Rarely sweat   ____Varicose veins
____Pain/cramping in legs   ____Swelling in hands/feet/ankles
____wounds/ulcerations on feet/legs   ____Palpatations
____High triglycerides   ____Bruise Easily
Blood pressure:

Metabolic function

____Diabetes/pre-diabetic/insulin resistant   ____Hypoglycemia
____Light-headed before meals   ____"Heaviness" after meals
____Thyroid disease/dysfunction   ____Hormonal dysfunction
____Hepatitis   ____Cirrhosis
____Jaundice   ____Alcohol/drug abuse
____Frequently hot   ____Frequently cold
____"Sugar Crashes"   ____Frequent snacking
____Abdominal pain   ____Ringing in the ears
Fasting blood glucose level (if known):
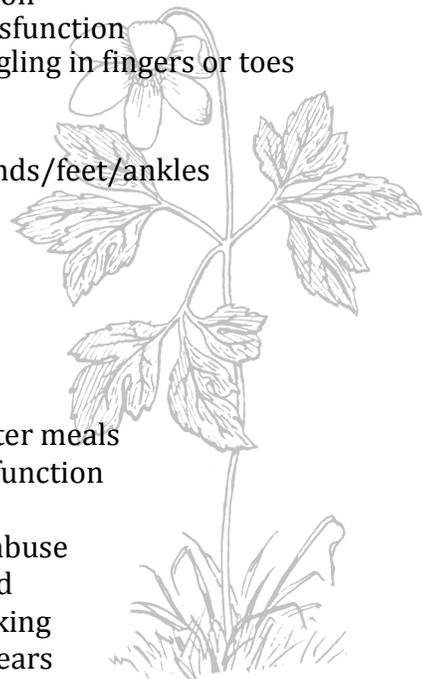
Immune function:

____Frequent illness
____Fever (temperature)
____Dust allergies
____Pet allergies
____Reactions to vaccines
____Muscle tenderness/soreness
____Recurrent infections

____Wounds heal slowly/prone to infection
____Seasonal allergies
____Mold allergies
____Chemical sensitivity
____Sensitivity to medication
____Joint tenderness/soreness
____Recurrent rashes/skin irritation

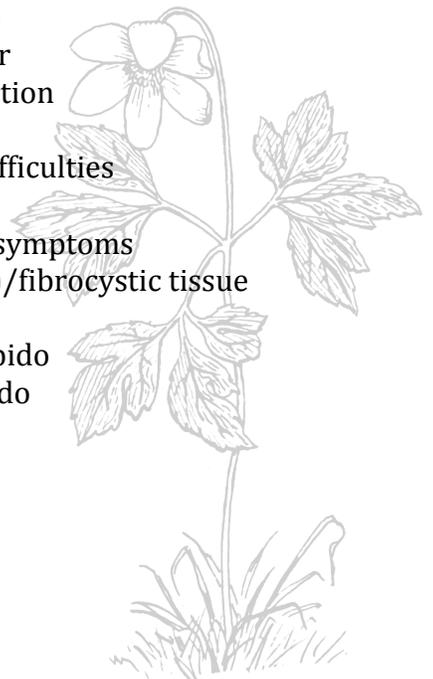Immunization(s) received:

Chronic conditions:

Nervous system:

____Tired upon waking
____Anxiety
____Depression
____Head injury
____"Pinched nerve"
____Trauma
____Radiating or shooting pain
____Tremors/shaking
____Chronic tension

____Dreams
____Panic attacks
____Spinal injury
____Herniated disks
____Paralysis
____Numbness/tingling
____Sciatic nerve pain
____Poor muscle control
____Constantly frazzled

Headache/pain recurrence: daily weekly monthly seasonal

Aggravating factor(s) for headache/pain recurrence:

Genital/Endocrine

____Erectile dysfunction (impotence)
____Urinary difficulties
____Prostatitis (BPH)
____Testicular cancer
____Hormone replacement
____Using birth control medication
____Uterine fibroids
____Endometriosis
____Breast tenderness
____Sexually active
____Hot flashes
____Painful intercourse

____Infertility
____Sexually active
____Prostate cancer
____Painful ejaculation
____Infertility
____Menopausal difficulties
____Uterine cysts
____Premenstrual symptoms
____Breast lump(s)/fibrocystic tissue
____Pregnant
____Underactive libido
____Overactive libido

Uterine
Results of last gynecological exam/pap smear:

Menstrual cycle (if not menstruating, describe your cycle in the past):
Duration (days):   Frequency (days):   Regular?

Blood Flow (heavy/med/light etc):   Clotting?
Number of pregnancies: Number of births: Miscarriages:

 Pre-mature births: Terminations:
Do you have any children?   Age(s):

Is there any chance that you are currently pregnant?

Contraceptive History: List the kind(s) if contraceptives you have used, if any, and for how long:

____Birth Control pills   ____ IUD   ____Condoms
____Chemical spermicides   ____Diaphragm   ____Rhythm
____ Mucous method

Any other gynecological problems?

_____
Please feel free to add any other information or thoughts about your physical health:

Current Emotional/Spiritual/Community health:

What are the predominant emotions in your life?

Rate how you feel about the following areas of your life (0 – poor 10 excellent

	0 to 10	Comments
Self		
Family		
Friends		
Partner(s)		
Community		
Work		
Personal goals		

Do you have a network for support you can call on?

What do you worry about?

What do you do for fun? What do you do to relax?

I always wanted to be:

I always wanted to do:

Is there one thing in your life you would like to change right now? Can you change it?

What is your desired goal for your clinic visit?

Ideally, what state of health can you visualize achieving for yourself?

Please attach results of lab work and any relevant testing.