SAGE WOMAN HERBALS & BODYWORK, LLC
Denise Tonkinson

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507-273-5975

Herbal Intake Form

Name:_____

Address: _____

_____

Telephone: (w)_____ (h) _____

Email:_____Preferred form of contact: _____

Occupation: _____ Gender (m/f, other): ____

Birth date: _____ Number of children: ___ Age(s): _____

_____

Please list all physicians and other healthcare providers or consultants (such as

Acupuncturist, massage therapist, etc) you see on a regular basis:

Name	Location	Type of Service

Please describe any relevant or major health-related issues:_____

_____

Family Medical History:

Father: _____

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

_ Other family members with pertinent issues, or recurring family health trends:

_____

_____

-_____

_____

PRESENT HEALTH STATUS

Do you currently smoke tobacco (y/n)? _____ If so, how many cigarettes/day? _____

If not, have you ever been a smoker in the past (y/n)? _____

For how many years did you smoke? _____When did you quit? _____

Do you currently drink alcohol (y/n)? _____ If so, list type, quantity, and frequency:

_____

List form and frequency of any regular exercise: _____

_____

How is your digestive system overall, do you experience indigestion, gas, constipation, diarrhea, bloating or other?_____

Check each column where symptoms apply and elaborate in space provided below if necessary. Please indicate with a √ any experiences below that you sometimes experience; two checks √√ for those which occur often; and use three checks √√√ for those which are a major concern.

Cardiovascular
_____High Blood Pressure
_____Low Blood Pressure
_____Pain in Heart
_____Poor Circulation/cold extremities
_____Swelling in Ankles/joint
_____Previous heart stroke/murmur
_____High Cholesterol

Muscles/Joints
_____Backache/upper or lower
_____Broken Bones
_____Mobility Restriction
_____Arthritis/Bursitis

Eyes, Ears, Nose, and Throat
_____Asthma
_____Ear Aches
_____Eye Pains, Dry/Wet
_____Failing vision
_____Hay Fever
_____Sinus Infection
_____Sinus Congestion
_____Sore Throat
_____Tonsils
_____Hearing Loss/Ringing Ears

Urinary/Kidney
_____Excessive Urination
_____Water Retention
_____Burning Urine
_____Kidney Stones
_____Lower Back Pain
_____Dark circles under eyes
_____Itchy Ears/eyes
_____Emotional Insecurity

Skin
_____Boils
_____Bruises
_____Dryness
_____Itching
_____Varicose Veins
_____Skin eruptions

Respiratory
_____Chest Pain
_____Difficulty breathing
_____Cough
_____Tuberculosis
_____Congestion

Gastro-Intestinal
_____Belching
_____Colitis
_____Constipation
_____Abdominal Pain
_____Liver Problems
_____Gall Stones
_____Ulcers
_____Indigestion

Sleeping Patterns
_____Insomnia
_____Waking in the night
_____Nite sweats
_____Restless sleep
_____Wake up tired
_____Difficulty falling back to sleep

Miscellaneous
_____Usually feel Hot/Warm
_____Usually feel Cold/Cool

Do you have headaches?_____How often?_____What are they like?_____

Cause?

Common Physical Activities

_Desk Sitting (how long)
_Sitting in a car (how Long)
_Calisthenics
_Swimming
_Walking
_Tai Chi
_Bike Riding
_Tennis
_Other

_Standing (how long?)
_Jogging/Running
_Aerobics
_Weight Lifting
_Yoga
_Hiking
_Horseback Riding
Bending/Lifting

Do any of the activities listed above aggravate a current health condition?_____

Have you had any operations? _____What year? _____

Any major injuries/accidents?_____ __What and when? _____

Any major illness or hospitalizations? _____What and when? _____ _

Current State of Emotions and Feelings

Please take a moment to answer the following questions:

Are you able to express your feelings and emotions?

Is there an excess of stress in your life?

What is causing the stress?

Are you satisfied with your job?

If in a relationship, are you satisfied with it?

If there is one thing in your life you would like to change right now, what is it?

_____

Can you change it?

Are you a "nervous type" person?

What are the things that make you most nervous?

_____

Supplements and Medications

List all herbs, vitamins, and dietary supplements you currently take, Citing brand name whenever possible (please bring all your supplement bottles with you for your appointment):
Use additional paper if needed

supplement	dosage

List all medications you are currently taking and **what they are taken for** (including aspirin, antacids, etc.), indicating whether they are over the counter (OTC) or prescription (P):
Use additional paper if needed

Name of Product/used for	OTC or P?	Dosage	Frequency (#/day)

Do you use any other drugs? Circle any that apply:

marijuana mushrooms ecstasy cocaine LSD heroin other:

Have you used any drugs in the past? Circle any that apply:

marijuana mushrooms ecstasy cocaine LSD heroin other:

List all medications, herbs, etc., to which you have a known allergy:

What are the areas of current complaint that you would like to address with an herbal program?

STATEMENT OF DISCLOSURE:

I am NOT a Medical Doctor, nor do I practice western medical assessment, diagnosis, or treatment. I do not claim to cure disease. I do not give advice about pharmaceuticals and medications at any time. If you have any questions or concerns about your condition, I highly recommend you discuss it with your physician. Never stop your medications without consulting with the physician or the licensed healthcare provider who prescribed them. This consultation is for educational purposes only. The remedies provided are a suggestion and are not meant as a substitute for any licensed medical treatment plan. Speak with your licensed medical provider before adding any herbal remedy to your prescription treatment regimen.

Denise Tonkinson, BA, NCBTMB, ARCB,
HERBALIST

Please sign below, verifying that you have read and understood the above statements:

Name (print) _____ Date: _____

Signature _____

Due to HIPPA privacy regulations, your information will be held confidential and not shared with anyone.