urban earth
natual wellness clinic

Patient Intake Form

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here or recorded during the consultation will not be released to any person except when you have authorized in writing to do so. Please complete the questionnaire as thoroughly as possible.

CONTACT INFORMATION

Name:_____

Date of Birth (d/m/y) _____/_____/_____Gender: _____

Address:_____City:_____

Province:_____Postal Code:_____e-mail:_____

Home Phone: _____Cell Phone:_____

Emergency Contact:_____Phone #:_____Relationship_____

Occupation: _____Usual Work Hours/Days_____

Living Situation: Alone Friends Partner/Spouse With Parent(s) With Children

Do you Have Pets? _____How Many?_____Type/Breed?_____

Do you Have Children? If so, how many and how old?_____

HEALTH PRIORITIES AND CONCERNS

Please list your main health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

VISION STATEMENT

What is your desired goal for your visit?

_____

_____

_____

How Did You Hear About Me?_____

HEALTH HABITS

Are you a smoker? _____ How many years?_____Amount per day _____Year Quit_____

Are you exposed to 2nd hand smoke?_____Do you use Recreational Drugs? Type?_____

Alcohol Use: Daily_____Several Times/wk_____Weekends Only_____Rarely ____ Never _____

Cups of coffee or caffeinated tea/day: _____# of pop/energy drinks per day: _____

# of 8oz glasses of water per day: _____Flavouring in water? _____

Do you take regular exercise? _____Frequency?_____

Type? _____Duration? _____

How often do you get direct outdoor sunlight exposure?_____for how long?_____

SLEEP DETAILS

BEDTIME: Typical Bedtime:_____To feel my best I should go to bed at:_____

Amount of time it takes to fall asleep:_____In the evening, I start to feel tired at:_____

If you have a hard time falling asleep, what is keeping you awake? ("I don't know" is a valid answer!)_____

_____

AWAKENINGS: Number of awakenings per night_____How long are you awake? _____

Best estimate of clock time(s) that you wake up?_____

The reason I wake up is ("I don't know" is a valid answer!):_____

_____

List any activities that you normally do during nighttime awakening(s) (i.e. restroom, eat, watch TV):_____

_____

_____

WAKE-UP TIME: Typical wake up time_____Desired Wake up Time?_____

How do you usually awaken (i.e. alarm clock, naturally, parent etc.)_____

How long does it take you to get out of bed after you first wake up?_____

How do you feel during the first 30 minutes after waking up in the morning?_____

NAPS How often (if ever) do you usually nap?_____

How long are your naps usually?_____How do you feel after a nap?_____

SLEEP ENVIRONMENT:

Average nighttime temperature in your bedroom:_____Noise Level?_____

Do you share your sleep environment with others?_____If so, who?_____

Do they disturb your sleep?_____Do you disturb theirs?_____

Do you use earplugs at night?_____Eye Masks/Shades?_____

Please describe what you usually do in the hour before bedtime:_____

_____

_____

PARASOMNIAS (DISRUPTED SLEEP)
Please check any of the following that are true for you:

_____I snore very loudly

_____ I sometimes awaken with a choking sensation

_____I sometimes stop breathing when I sleep

_____I grind my teeth when I sleep

_____I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension or unhappiness

_____When I wake during the night, I often have to get up and go to the bathroom.

_____ I sweat a lot when I sleep.

_____My legs twitch or jerk while I am sleeping

_____I have a creeping, crawling sensation in my legs when I lie down to sleep.

Do you wake up feeling rested? Yes No Sometimes

Have you ever been diagnosed with a sleeping disorder? _____If yes, what was the diagnosis? _____

_____

ENERGY LEVELS

On a scale from 1-10 how would you rate your energy levels:

On an average day?_____On a good day?_____On a bad day?_____

Do your energy levels improve or decrease after the following activities?:

Meals:_____Naps:_____Exercise:_____

Do you experience any sudden energy drops throughout the day? _____If yes, what do you associated them with?_____

Do your energy levels fluctuate monthly?_____Seasonally?_____

STRESS MANAGEMENT

On a scale from 1-10 how would you rate your stress levels on an average day:_____

How often do you allow yourself to do nothing?_____

Are you a multi-tasker?_____ Do you get impatient if people hold you up?_____

When you are on holidays, do you get sick or start to feel down?_____

What are your 5 greatest sources of stress?
1._____
2. _____
3. _____
4. _____
5. _____

What are your 5 sources of joy/satisfaction?
1._____
2. _____
3. _____
4. _____
5. _____

Do you have any techniques to relieve stress? How often do you use them?

TECHNIQUE HOW OFTEN

_____
_____
_____

Have you ever been diagnosed with a mental health condition?_____

If yes, please explain:_____
_____

NUTRITION AND DIET

Dietary preferences/restrictions: _____
_____

How would you describe your relationship with food? _____

Who is responsible for cooking/food preparation in your family?_____

Do you feel like you have a healthy diet?_____

If not, what is your biggest challenge holding you back from achieving a healthy diet_____
_____

Sample of a typical day: **Time?**

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Bedtime Snack:

Fluids:

ALLERGIES AND DRUG REACTIONS

(List and describe the reaction. Please include any drugs, foods, chemicals, pollens, molds, insects and animals that you react to)

MEDICATIONS

Please list the medications you are currently taking. If you require more room, please attach a separate sheet.

Medication Name What is it for? Strength (mg) and Dose(how often)

SUPPLEMENTS, HERBS, HOMEOPATHICS

Please list the supplements, herbs, homeopathics and other remedies that you take on a regular basis. If you require more room, please attach a separate sheet.

Remedy Brand Name Potency (mg/IU/ml) Dose

FOR WOMEN ONLY

MENSTRUAL HISTORY

Please complete this section to the best of your ability, even if you no longer menstruate.

Age of first Period:_____ Length of Cycle _____ Is/was your Period Regular?_____

Duration of Bleeding:_____ How many days is the flow heavy?_____ Light? _____ Clots?_____

Menstrual Cramps?_____ If yes, on which days?_____

PMS?_____ Describe your symptoms_____

_____

PREGNANCY AND BREASTFEEDING

Are you currently Pregnant? Yes No Not Sure If Yes, how many weeks_____

Are you currently Breastfeeding? Yes No

MENOPAUSE/PERIMENOPAUSE

Date of last period_____

Menopausal symptoms you are currently experiencing_____

_____

_____

Symptoms experienced in the past:_____

_____

WAIVER

I, the undersigned, hereby confirm that I am consulting with Mara Jones, CHT of my own free will. I understand that the Province of British Columbia does not at this time license Clinical Herbal Therapists under the B.C. healthcare act.

I understand there will be no diagnosis made, nor prescription given, but that Mara will offer a review of my general health and will make herbal, nutritional and lifestyle recommendations. I understand the importance of frequent monitoring to revise the treatment protocol as the symptom picture changes and agree to keep Mara Jones, CHT apprised of any changes in medications while under her care.

I hereby assume any risks and I do clearly swear that every decision that I make will be by my own will. I understand that I am free to act upon or disregard the recommendations of Mara Jones as I so choose and I hereby release and waive all my rights against Mara Jones and Urban Earth Teas and Wellness.

I agree this is a legal and binding agreement and deem it so with my signature.

Print Full Name:_____

Signature:_____ Date:_____

Parent/Guardian/Relative Giving Consent (If Client is under 16 years):

Print Name:_____ Signature:_____