# Mini Consultation Intake Form

Date: _____ Weight: _____ Age: _____

Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail: _____ May we contact you? Yes No

Your personal information is completely confidential. We will never share it with anyone.

What health issue are you coming in about? _____

Please check below if you have experienced any of the following:

**Nervous System:**
Memory Loss ____
Fatigue ____
Depression ____
Headaches ____
Insomnia ____
What would you rate your level of stress (0= no stress, 10 = maximum stress) _____
How many hours of sleep do you get on an average night? _____

**Heart:**
High Blood Pressure ____
Varicose Veins ____
Heart Problems ____
High Cholesterol ____

**Skin:**
Acne ____
Eczema ____
Skin Rashes ____
Psoriasis ____
Skin Fungus ____

**Digestive/Liver:**
Constipation ____
Diarrhea ____
Bloating ____
When was the last time you took antibiotics? _____
Do you have a bowel movement: 1 or more times a day ____ Less frequent_____ If so, how often? _____
Food Allergies/Sensitivities Yes No If so, what are you allergic/sensitive to? _____
Have you ever done a fast or liver cleanse? Yes No If so, when? _____

**Kidney:**
Kidney Problems ____
Urinary Tract Infections ____
Fainting Spells ____
How much water do you drink every day? _____

**Immune:**
Frequent Cold or Flu ____
Wounds Heal Slowly ____
Frequent Cold Sores ____
Swollen Lymph Nodes ____
Cancer ____

**Women's Health:**
Irregular PAP ____
Fibroids ____
Endometriosis ____
Difficulty Getting Pregnant ____
Hot Flashes ____
Currently Pregnant ____

**Men's Health:**
Frequent Urination ____
Reproductive Issues ____
Prostate Problems ____
Painful Urination ____

**Respiratory:**
Sinus Problems ____
Smoker ____
Lung Problems ____
Air-borne Allergies ____
Asthma ____

**Metabolic:**
Diabetes ____
Hold Extra Weight in Torso/Stomach ____
Feel Agitated/Low Functioning if Not Eating Regularly ____

List any medications you are currently taking: _____

List any herbs or supplements you are currently talking: _____

List any know allergies: _____

Have you had any surgeries? _____

Anything else I should know? _____

Recommended Follow Up:

Complicated health issues: 1 • 2 weeks Moderate Health Issues: 2 • 4 weeks Healthy follow up: as needed

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**Please Note:**
We do not diagnose or prescribe. Our services are strictly educational, offering clients the tools to enhance their own well-being and help them make educated decisions about their own health care. Herbal therapeutics are not meant to replace medical diagnosis or treatment. If symptoms persist, please contact your doctor.

I understand and agree to the above terms.

Name: _____ Date: _____