HerbsongFarm.com

An Integrated approach using botanicals for health.

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Intake Form

Please fill out prior to our appointment

Name____ Date of birth_____________

Height________Weight___________ Relationship status_____________________________

Do you have children? Yes/No If yes, how many and ages____________________________

Occupation____

Phone number____

E-mail:____

What is the main reason for your visit today? (diagnosis, main complaint, symptoms)

Do you have a medical diagnosis? Please include any recent significant lab reports or vital signs.

Do you have allergies? Please specify foods, medications, environmental

Hobbies, skills, interests, favorite pastimes

Exercise- what type and how often

Are you currently under the care of a health care provider? What type of provider and how often do you see them? (please include alternative practitioners as well)

Current prescription and over the counter medications and treatments

Current herbal and nutritional supplements

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Past Medical History

Significant Illness (circle):

Heart disease High blood pressure Stroke Hepatitis A B C Diabetes Seizures

Depression/Anxiety Asthma Thyroid disease Chronic pain Chron's IBS Migraines

Cancer: type____

Autoimmune :type____

Other:____

Past surgeries, major accidents or hospitalilzation (please include dates)

Alcohol use? _____________drinks/day __________________drinks/week

Tobacco use? How many cigarettes per day? __________________________

Recreational drug use? ____

How much water do you drink each day? ____________glasses (8oz)

What else do you regularly drink?

Emotions and stress:

Which of these feelings dominate your life? (circle 3):

Joy Happiness Anger Sadness Fear Sympathy Worry Depression Anxiety Peace

Do you feel that you are under stress in your life?

What kind of stress do you deal with?

What happens when you are under a lot of stress? (Physically and emotionally)

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Please indicate approximate dates and describe the nature of any traumatic experiences you have had in the last 7 years (divorce, loss of lover, loss of job, moving, accidents, deaths, etc)

Sleep patterns:

Do you sleep through the night?

Any problems falling asleep?

What are your favorite hours to sleep?

Generally, how many hours do you need to feel rested?

Do you feel rested when you wake in the morning?

Goals:

What are your goals for using cannabis?

What might stand in the way of you achieving your goals?

What gives you the most joy in your life?

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What will you do when you are well that you are not doing now?

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