

Client Intake Form
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Note: All case history notes and medical information recorded here or provided by you during consultation(s), is/are kept strictly confidential. Information contained here will not be released to any person except with your written authorization.

Waiver of Liability:

I, the undersigned, hereby confirm that I am consulting with Paulina Nelega, Clinical Herbalist (RH), of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the above named practitioner will offer an assessment of my general health and will make herbal and dietary recommendations. I understand the importance of regular monitoring to revise the treatment protocol as the symptom picture changes.

I understand and agree with the above: _____
(Signature) (Date)

Please complete this questionnaire as thoroughly as possible.

Personal Information

NAME (Please Print) _____
(First Name) (Last Name)

DATE of BIRTH _____ AGE _____

SUITE/STREET _____ CITY _____ POSTAL CODE _____

TELEPHONE _____ CELL _____ EMAIL _____

OCCUPATION _____

EMPLOYMENT STATUS: Full-time ___ Part-time ___ Student ___ Retired ___ Unemployed ___ Other _____

PARTNER STATUS _____ CHILDREN (#/ages) _____

Where did you hear about my clinic/services? _____

What is/are the major health concern/s that brought you here today?

When did this condition begin? _____

Are you currently receiving care from any other health professional(s)? (Name) _____

For what condition(s)? _____

Please list below any Supplements and Medications (Prescription and Over-the-Counter) that you are currently using (continue list on back if necessary):

Medication/Supplement/Herb Name	Brand Name	Potency (mg or IU)	Dose	Frequency
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Do you have any infectious diseases that you are aware of? Yes ___ No ___ If yes, please list: _____

Women: Is there any chance that you are pregnant? Yes ___ No ___

Allergies or sensitivities? (drugs, pollens, foods, etc.) _____

Is there any reason that you could not take herbal remedies made with alcohol? Yes ___ No ___

Have you had any operations or been in hospital for any reason? (date and reason)

Accidents/ Injuries (briefly describe):

More than 5 years ago _____

Less than 5 years ago _____

Family Medical History *Please complete this section only for family members with particular health problems.*

CURRENT AGE (if deceased, Age of death) HEALTH PROBLEM

Father _____

Mother _____

Brothers/Sisters _____

Children _____

Other close blood relatives _____

Personal Health Habits

Height _____ Current Weight _____ Weight one year ago _____

Are you a current smoker? ___ How many years? ___ Amount per day? ___ Have you smoked in the past? ___

If so, when did you quit? ___ Do you use recreational drugs ___ What type? _____ Frequency? ___

Are you involved in regular exercise? ___ Type? _____ Frequency? _____ Duration? _____

Diet *Please also provide 3-day Diet Diary – everything you eat and drink, over 3 consecutive days*

Do you drink alcohol? ___ Type? _____ Frequency? _____ Water? ___ Amount per day _____

Do you drink coffee? ___ Amount _____ Black Tea? ___ Amount _____ Green/Herbal Tea? ___ Amount _____

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 restricted diet? Please describe and indicate when:

Health Concerns *Please check off if you have experienced any of these within the last 6 months:*

Skin and Hair

- ___ Rashes
- ___ Eczema
- ___ Change in any moles
- ___ Poorly healing sores
- ___ Pimples
- ___ Change in skin texture
- ___ Hives
- ___ Dandruff
- ___ Spider veins, broken capillaries
- ___ Itching
- ___ Loss of hair

Any other noted problems with skin, nails or hair? _____

Head, Eyes, Ears, Nose and Throat

- ___ Poor vision
- ___ Blurred vision
- ___ Eye pain
- ___ Cold sores
- ___ Sore throat
- ___ Cataracts
- ___ Poor hearing
- ___ Grinding teeth
- ___ Canker sores
- ___ Swollen glands
- ___ Glaucoma
- ___ Ringing in ears
- ___ Clicking jaw
- ___ Nosebleeds
- ___ Sinus congestion
- ___ Spots in front of eyes
- ___ Earaches
- ___ Facial pain
- ___ Dizziness
- ___ Mucous in throat
- ___ Frequent colds

Any other problems with the head region? _____

Cardiovascular

High blood pressure Low blood pressure Chest pain Fainting
 Irregular heart beat Cold hands or feet Ankle swelling Palpitations
 Easy bruising Varicose veins Blood clots Breathing difficulties

Any other problems with the heart or circulation? _____

What is your blood pressure? _____ Last reading done: _____

Gastro-Intestinal

Nausea Vomiting Diarrhea Constipation
 Black stools Bad breath Indigestion Abdominal pain
 Heartburn Gas Blood in stools Mucous in stools
 Rectal pain Haemorrhoids Bloating Food cravings
 Poor appetite Gallstones Ulcers Difficulty swallowing
 Colitis/ IBS Liver problems

of bowel movements per day Loose Normal Hard

Stools: float sink bad odour no odour blood in stool

Do you rely on any of the following for bowel elimination? Yes No

Enemas Laxatives What type/brand? _____ How often? _____

Any other digestive problems? _____

Respiratory

Cough Bronchitis Asthma Pneumonia
 Coughing blood Pain on breathing Shortness of breath without exertion
 Difficulty breathing when lying down
 Production of phlegm - if yes, what colour? _____

Any other problems with breathing? _____

Urinary

Pain on urination Frequent urination Blood in urine Urgency of urination
 Irregular flow Decrease in flow Inability to hold urine Feeling of incomplete emptying
 Burning during urination Difficulty starting/stopping flow Interstitial Cystitis Kidney stones
 # of bladder infections in last 12 months Did you take antibiotics? How many times?
 Impotency or erectile difficulties Prostate enlargement/BPH PSA? Result/date: _____

Any other problems with urination? _____

Musculoskeletal

Neck pain Back pain - if yes, where is the pain located? _____
 Stiffness (general) Muscle pain - if yes, where? _____
 Muscle weakness Broken bones Reduced range of movement - if yes, where _____

Do you see a Chiropractor or Massage Therapist? (Name) _____

Any other musculoskeletal problems? _____

Female Reproductive

Age of first period Length of each cycle Duration of bleeding Severe menstrual cramps Anemia
 Light flow Heavy bleeding Irregular bleeding Colour of blood Clotting
 Cervical dysplasia Endometriosis Uterine Fibroids Ovarian cysts Infertility
 Fibrocystic breasts Vaginal itching Discharge - colour/consistency/odour _____
 Vaginal infection? Type (Candida/yeast, BV, other) _____ When? _____ Type of treatment _____
 Pain with intercourse Dramatic mood swings
 Hot flashes Absence of cycle Break-through bleeding Dry vaginal lining Osteoporosis
 Hysterectomy (date) _____ Tubal ligation (date) _____ Mastectomy (date) _____ Lumpectomy (date) _____

PMS - if yes, list symptoms _____
 ___ HRT – if yes, type/dose/started: _____ Date & result of last PAP _____
 Menopausal difficulties – if yes, list symptoms you have had and/or are currently experiencing: _____

Do you have breast implants? ___ Since: ___ Have you noticed any problem with them? _____
 ___ # of Pregnancies ___ # of Births ___ Miscarriages ___ Premature births ___ Terminations ___ Tubular Pregnancies

Contraceptive Use Please indicate type used and for how long:

Birth Control Pill (name of): _____ IUD ___ Condoms ___ Diaphragm ___
 Spermicides ___ Rhythm and/or Mucous method ___ Other _____

Any other gynecological problems? _____

Male and Female Sexual Health Please indicate if you have received treatment for any of these:

___ Herpes ___ HPV (Genital Warts) ___ Chlamydia ___ Gonorrhea ___ Pelvic inflammatory disease (PID)
 ___ Other Sexually Transmitted Infection(s) – if yes, please indicate type/when _____

Neuropsychological

___ Poor sleep ___ Hours of sleep per 24 hours
 ___ Poor memory ___ Difficulty concentrating ___ Foggy or ‘spacey’ feeling ___ Depression ___ Irritability ___
 Anxiety ___ Seizures ___ Headaches ___ Migraine - frequency: _____ ___ Loss of balance ___ Lack of
 coordination ___ Numbness
 ___ High stress levels – on a scale of 1-10 (with 10 being the highest), what is your current stress level: _____

Stress management techniques: _____

Any other neurological problems? _____

General

___ Fatigue ___ Fevers ___ Chills ___ Night sweats ___ Excessive thirst
 ___ Slow metabolism ___ Sudden energy drops ___ Intolerance to heat or cold
 ___ Have you taken antibiotics in the last 12 months (other than any already noted) – if yes, which ones and for what?

___ Have you ever been exposed to any pesticides, toxic chemicals, heavy metals, radiation, or other toxins encountered
 beyond daily living? If yes, please describe: _____

___ Mercury amalgam fillings ___ Root canals – if yes, how many and when done: _____

Have you noticed any problem with your root canals? Please describe: _____

Any other health concerns you wish to mention? _____

Personal

How do you feel about the following areas of your life? Check appropriate boxes and please make any comments you wish:

	GREAT	GOOD	FAIR	POOR	COMMENTS
Self					
Work					
Spouse or significant other					
Sex					
Family					
Personal Goals/ Life Purpose					

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? _____

Do you have tools or techniques to adequately relieve stress? _____

Do you have a strong support network and sense of connection with friends, family, community? _____

Are you satisfied with your current state of "life"? _____

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

Are you a 'nervous' type of person? What are the things that make you most nervous? _____

Do you sleep well and awake refreshed? _____

What feelings do you most often experience in your life, e.g., joy, happiness, anger, sadness, fear, sympathy, worry, depression or _____

If you were to choose one or two emotions that seem to predominate in your life, what are they? _____

Vision Statement

What is your desired goal for your clinic visit? _____

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