Bonnie Bloom Herbalist

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INTAKE + HISTORY FORM

Date

Date of Birth

NAME

Address

Phone

Cell

Email

REASON/S FOR CONSULT

DO YOU HAVE ANY PREVIOUS EXPERIENCE WITH

(yes or no)

herbs

natural supplements

acupuncture/bodywork

DIET

Typical Breakfast

Typical Lunch

Typical Dinner

Desserts and/or snacks

Favorite foods or cravings

Beverages

Body weight in pounds

Water drunk in ozs per day.

SLEEP PATTERN

(check one)

fall asleep easily

can't fall asleep

wakes how times per night

what times do you wake in the night

do you feel rested?

How do you feel in the AM?

BOWELS

move how many times daily?

(select below if applicable)

every 2-3 days

less often

difficult

easy

loose

incomplete

hard

complete

do you take probiotics?

how much?

MOOD + EMOTIONS

currently

past issues

LIBIDO

absent

average

low

good

WORK

(select any that are applicable)

satisfying

work too hard

unsatisfying

work a reasonable amount of hrs

retired

avg. per week

unemployed

HOBBIES OR FAVORITE ACTIVITIES

EXERCISE

(select any that are applicable)

intense

average

infrequent

not at all

frequency

type of activity

level of enjoyment

ENERGY LEVEL

exhausted

tired occasionally

up and down

good energy

CYCLE

Menses

Menopausal

Number of Preg

Number of births

Birth Control

HEALTH

Medications

Surgeries

Significant Medical History with dates

Significant mental/Emotional History with dates

Childhood issues and illnesses

Relationship to family or origin

Current network of support

Any other information that would be useful to share