EMERGENT
HERBS & NUTRITION

Intake Form

Personal Information

Name (first & last)

Address (if herbs or supplements will be shipped to you)

Phone

☐ Recieves texts?

Email

Birth Date (M/D/Y)

Height **Weight** lbs **Gender at birth**

Health Assessment

What is the main reason for your visit today?

Are there any other health issues you would like to address today?

How would you rate your overall health on a scale of 1-10 (1= poor, 10= excellent)

1	2	3	4	5	6	7	8	9	10

How would you rate your overall outlook on life on a scale of 1-10 (1= negative, 10= positive)

1	2	3	4	5	6	7	8	9	10

How would you rate your overall stress level on a scale of 1-10 (1= no stress, 10= extremely stressed)

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Severe Symptoms

Are you experiencing any of the following symptoms? (*Check all that apply*)

☐	Severe pain	☐	Numbness/tingling	☐	Lumps, swellings
☐	Fever	☐	Severe headache	☐	Depression/suicidal
☐	Vomiting	☐	Blood in urine	☐	Severe fatigue
☐	Diarrhea	☐	Sudden rash w/ fever	☐	Night sweats
☐	Shortness of breath	☐	Severe stomach pain	☐	Black tarry stool
☐	Chest pain/tightness	☐	Recent fainting	☐	Frequent urination
☐	Bleeding of any kind	☐	Visual disturbances	☐	Other:

Health Information

Do you have any diagnosed health conditions? ☐ No ☐ Yes If yes please list:

Is there any chance that you are or could become pregnant? ☐ No ☐ Yes

Are you under the care of a physician at this time? ☐ Yes ☐ No

Are you allergic to any medications or herbs? ☐ Yes ☐ No If yes please list:

Are you allergic to any foods? ☐ No ☐ Yes If yes, please list type and severity of the allergic reaction:

Do you use tobacco or nicotine products? ☐ No ☐ Yes ☐ Never

If yes: ☐ Times per day ☐ Times/week

Ex-smoker? How long ago? Ex-vaper? How long ago?

Do you consume alcohol? No Yes Never

If yes: Times per day Times/week Times/month

Are you a recovering alcoholic? No Yes If yes, how long sober?

Do you use cannabis? No Yes Never

If yes, check the type used: Smoking Vape Oils CBD Edibles

If yes: Times per day Times/week Times/month

Ex-user? How long ago?

How often do you drink caffeine? Times per day Times/week

Times/month Never

How often do you drink soft drinks? Times per day Times/week

Times/month Never

How often do you drink energy drinks? Times per day Times/week

Times/month Never

Do you have any other addictions or habits? No Yes

If you want to share more:

Have you experienced a major trauma in any way? (Physical, emotional, and/or mental?) No Yes

If you want to share more:

How often do you exercise? Minutes/day Times/week Never

If yes, what type of exercise?

On average, how many hours of sleep do you get per night?

Weekdays Weekends

Is your sleep disturbed? ☐ **No** ☐ **Yes** **If yes, how?**

Prescriptions, Herbs, Vitamins, Supplements and Over the Counter Rxs

Please list all that you are taking

Name of medication/herb/ supplement	**Dose** i.e, 500mg, 1 tsp. etc	**Frequency Taken** 1/day, 3/day, as needed etc.	**Prescribed (RX) or Self Care (SC)**