

TONIC
CLINICAL INTAKE FORM

Attending Herbalist: _____
140 E. German St. Shepherdstown, WV 25443 * (304) 870-4527

PERSONAL HEALTH PROFILE

Name _____ Daytime Phone _____

Email _____ Evening Phone _____

Address _____

Where and when have you lived/traveled outside the U.S. or Canada? _____

Date of Birth _____ Age _____ Gender _____ Ancestry/Ethnicity _____

Emergency Contact _____ Relationship _____

PRESENT HEALTH CONCERNS

Main reason for visit: *major complaints, symptoms, concerns, etc.*

How long have you had these conditions?

What was going on in your life in the months preceding this condition?

Do you have any symptoms that worsen or improve with: ___Exertion ___Heat ___Cold ___Pressure
Please Describe:

Do you have a medical diagnosis? *Please include any significant lab results or imaging*

Physician's Treatment:

Current or recent prescription medications (*including dosages and approximate length of time you have used each*)

Current or recent over the counter medications (*e.g. laxatives, pain relievers, antacids, etc.; Include dosage*)

Current/recent vitamins, minerals, herbs, homeopathic remedies or other supplements: *include dosage*

Current or Recent Health Care Practitioners: *please list names and treatments not yet mentioned*

HEALTH HISTORY

What other health related issues have you had in the past? *Please describe symptoms and relative dates*

Please list any previous medications and treatments: _____

Please list any operations you have had and the date: _____

Please list any major injuries/accidents, including date: _____

Please list any traumatic experiences not treated medically (*divorce, loss of job, death of loved one, etc*):

Have you had unusual reactions to any drugs or herbs?

Do you have any allergies, sensitivities, or ongoing infections?

Known exposure to toxic chemicals, mold or heavy metals?

FAMILY MEDICAL HISTORY

	Alive or Deceased?	Age or Age at Death	Present Illness or Cause of Death	Briefly describe your relationship
Mother				
Father				
Sisters				
Brothers				

Check illnesses which have occurred in any of your blood relatives:

Diabetes Cancer Bleeding Tendency Kidney Disease Tuberculosis
 Allergy Anxiety Alcoholism Emotional Abuse Physical Abuse
 Heart Disease Stroke High Blood Pressure Other _____

LIFESTYLE:

Education: _____ Occupation _____

For how long? _____ Hours per week? _____ Do you enjoy your work? _____

Previous occupation(s) _____

Relationship Status _____ Children? _____

Ages of Children _____ Do you live with: Spouse _____ Partner _____

Parents _____ Child(ren) _____ Friends _____ Relatives _____ Alone _____ Pets _____

Do you feel safe? _____ Do you feel appreciated? _____ Do you feel supported? _____

Do you smoke? _____ How much per day? _____ If you used to smoke, when did you quit? _____

What behaviors or habits do you engage in regularly that you believe support your health? _____

What behaviors or habits do you engage in regularly that you believe are destructive to your health? _____

Please describe any current or past use of addictive or recreational substances: _____

What kind of exercise do you get on a regular basis? _____

How stressed do you feel on a scale from 1-5 (*1 = no feelings of stress; 5 = completely stressed out*)

What are the major sources of stress for you?

How do you respond to these stressors?

ENERGY

How are your energy levels in general? _____
What time(s) of day are your energy the highest? _____ lowest? _____
Have your energy levels changed markedly at any point in the recent past? _____
If so, what preceded this change? _____

SLEEP

Do you have any difficulty falling asleep? _____ Staying asleep? _____
What time do you go to bed? _____ What time do you wake up? _____
Do you feel rested? _____ Do you dream? _____
If you wake in the middle of the night, how often do you wake? _____
What times of night do you wake? _____ What wakes you? _____

TEMPERATURE

Do you run hot or cold? _____
What parts of your body feel the hottest/coldest? _____
What is your favorite temperature/ climate? _____
What part of the day are you warmest and coldest? _____

DIET

How would you rate your appetite? Ravenous Strong Average Weak Almost none

List the types of foods you eat for a typical:

Breakfast _____

Lunch _____

Dinner _____

Snacks & Times eaten _____

Fluids _____

What foods do you crave? _____

What are your favorite and least favorite foods and flavors? _____

Do you have any known food allergies? No ___ Yes ___ List: _____

Do you consume any of the following: *Please indicate: s= sometimes, o= often, n=never*

- Soy products Meat Fish Eggs Dairy Poultry
 Beer Wine Coffee Soda Tea Sugar Candy
 White Bread Whole grain bread Cold cereal Whole grains or quinoa
 Processed foods Fast food Fried Foods Eating out at a restaurant
 Raw veggies Cooked veggies Raw fruit Dried or cooked fruit
 Butter Margarine Canola, soy or corn oils Olive, coconut or palm oils
 Organic produce and grains Pastured/Grass-fed eggs, poultry, meat and dairy

Do you often: *Check all that apply*

- Feel rushed during your meals Eat without distractions
 Eat while standing, reading, watching TV Eat regularly timed meals
 Over eat Forget to eat meals Eat until satiated or just under

BODY SYSTEMS

please rate as 1= sometimes 2= often 3= major concern or P = past condition. Leave blank if not applicable

DIGESTION:

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Anorexia nervosa | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Mouth Ulcers |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Parasites Polyps |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Flatulence | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Bulemia | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Receding Gums |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> History of Hepatitis | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Often forget to eat | <input type="checkbox"/> Strong appetite, eat regularly | <input type="checkbox"/> Can skip meals easily |
| <input type="checkbox"/> Anxious or faint if skip a meal | <input type="checkbox"/> Get irritable if skip a meal | <input type="checkbox"/> Tired/heavy after meal |
| <input type="checkbox"/> Other: _____ | | |

ELIMINATION: *please indicate any usual qualities*

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Loose stool | <input type="checkbox"/> Pale gray stool |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Food particles in stool | <input type="checkbox"/> Pencil thin stool |
| <input type="checkbox"/> Mucus in stool | <input type="checkbox"/> Changes in bowel habits | <input type="checkbox"/> Stool that floats |
| <input type="checkbox"/> Painful defecation | <input type="checkbox"/> Quick defecation after eating | <input type="checkbox"/> Other: _____ |

How frequently do you have a bowel movement? _____

Describe the color, shape, & size of a typical BM *(I know it's awkward, but it can be very useful information)*

URINARY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Cravings for salt |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Excessive fear/fearlessness |
| <input type="checkbox"/> Water retention/edema | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Frequent urge to urinate |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Gout | <input type="checkbox"/> Wake up at night to urinate |
| <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Frequent thirst | <input type="checkbox"/> Incomplete emptying |

Describe the frequency, color and smell of your urine _____

RESPIRATORY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Fluid in lungs | <input type="checkbox"/> Pleuritis |
| <input type="checkbox"/> Postnasal drip | <input type="checkbox"/> Recurrent influenza | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Clear, thin mucus | <input type="checkbox"/> Yellow/Green mucus |
| <input type="checkbox"/> Dry, hard mucus | <input type="checkbox"/> Easy to cough up mucus | <input type="checkbox"/> Other: _____ |

CARDIO-VASCULAR:

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> History of Heart attack | <input type="checkbox"/> History of stroke | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Hands cold, clammy or dry | <input type="checkbox"/> Hands warm, sweaty | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Swelling in ankles/joints | <input type="checkbox"/> Other: _____ | |

IMMUNE/LYMPHATIC:

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis (rheumatism) | <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Frequently sick |
| <input type="checkbox"/> Low-grade fever | <input type="checkbox"/> Low white blood cell count | <input type="checkbox"/> Injuries heal slowly |
| <input type="checkbox"/> Swollen lymph glands | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> Lymphatic congestion | <input type="checkbox"/> Feel "unclean" | <input type="checkbox"/> Other: _____ |

SKIN:

- | | | |
|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Easily sunburned | <input type="checkbox"/> Moles |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Eczema and dermatitis | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Slow wound healing |
| <input type="checkbox"/> Dry/itchy scalp or hair | <input type="checkbox"/> red, burning or flushed skin | <input type="checkbox"/> Oily, damp scalp or hair |

MUSCULOSKELETAL:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Arthritis (not rheumatoid) | <input type="checkbox"/> Mobility restriction | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Backache upper/lower | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Torn ligaments | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Stiffness in joints | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Other: _____ |

EARS, NOSE, THROAT,

- | | | |
|---|--|---|
| <input type="checkbox"/> Failing vision | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Tinnitus/ringing in ears |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sore or bleeding gums |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Laryngitis | <input type="checkbox"/> Frequent nose bleeds |
| <input type="checkbox"/> Frequent stuffy nose | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other: _____ |

NERVOUS SYSTEM:

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Herpes or shingles outbreaks | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Obsessiveness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Overwhelm | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Memory loss or changes | <input type="checkbox"/> Mental fog | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Insomnia |

If you get headaches, can you describe the pain, location & triggers?

Which emotions do you experience most frequently? *Please use o=often, s=sometimes, n=never*

- | | | | | |
|---------------------------------------|-------------------------------|-------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Joy | <input type="checkbox"/> Sadness | <input type="checkbox"/> Grief | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fear | <input type="checkbox"/> Melancholy | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Lethargy |

ENDOCRINE/METABOLISM

- | | | |
|---|--|--|
| <input type="checkbox"/> Adrenal fatigue | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Elevated Blood Sugar |
| <input type="checkbox"/> Diabetes (type I or II?) | <input type="checkbox"/> Metabolic Syndrome | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Overweight, difficulty losing | <input type="checkbox"/> Difficulty gaining weight |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> Pineal | <input type="checkbox"/> Other: _____ |

REPRODUCTIVE MEN:

- Sexually transmitted disease; List type if known: _____
- | | | |
|---|--|--|
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> Impotence | <input type="checkbox"/> Painful ejaculation |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Low sperm motility |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Difficulty with urination | <input type="checkbox"/> Other: _____ |

REPRODUCTIVE WOMEN

- Pregnancies (dates): _____
- Miscarriages (dates): _____ Abortions (dates): _____
- Contraceptive use: List type and duration of use: _____

- Sexually transmitted disease; List type if known: _____
- Hysterectomy (date): _____ Reason: _____
- | | | |
|--|--|--|
| <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Vaginal itching/discharge | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Vaginal infection |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Fibrocystic breasts | <input type="checkbox"/> Lack of sex drive |

Menstruating Women:

- | | | |
|--|---|--|
| <input type="checkbox"/> Absence of menstrual cycles | <input type="checkbox"/> Irregular cycles | <input type="checkbox"/> Bleeding between cycles |
| <input type="checkbox"/> Dramatic mood swings | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Crave sugar before menses |
| <input type="checkbox"/> Menses slow to start | <input type="checkbox"/> Menses always lengthy | <input type="checkbox"/> Heavy bleeding |
| <input type="checkbox"/> Painful menstrual cramps | <input type="checkbox"/> Clots in menstrual blood | <input type="checkbox"/> Anemia |

Please elaborate on any inconsistencies or concerns you have about your cycle:

Menopausal Women:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Dry vaginal lining | <input type="checkbox"/> Hormone replacement therapy | <input type="checkbox"/> Sore muscles |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Estrogen replacement therapy | <input type="checkbox"/> Other: _____ |
- _____

Please use this space to describe anything else you feel is relevant to your current health concerns:

TONIC,LLC

ASSUMPTION OF RISK, RELEASE, COVENANT NOT TO SUE AND AGREEMENT TO HOLD HARMLESS

I hereby accept and assume any and all risk and liability associated with any treatment and/or products provided by Tonic, LLC, and its agents, owners and/or employees.

I hereby consent to the performance of an evaluation on me (or on the person named below for whom I am legally responsible), which may include but is not limited to pulse and tongue evaluation and the receipt of information regarding herbs, supplements, diet & lifestyle for the purpose of enhancing my health.

I understand that herbal and diet therapy is not intended as a diagnosis, prescription or treatment for any disease, physical or mental. I further understand that the agents, owners and/or employees of Tonic, LLC are not licensed to provide any medical treatment or advice.

The herbs and nutritional supplements that may be recommended are traditionally considered safe in the practice of Herbalism; however, it is impossible to predict how an individual may respond to a particular herb. Some possible side effects of taking herbs include but are not limited to nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, and hives. I understand and do not expect the clinical herbalist to be able to anticipate and explain all possible risks and complications of the recommendations.

I understand that recommended herbs are to be consumed or applied as directed, and that I am to immediately stop using them and to notify herbalist of any unanticipated or unpleasant effects associated with the use of herbs.

I understand that some herbs may be inappropriate during pregnancy. I will notify the herbalist if I am or become pregnant. I understand that some herbs may affect medications. I will notify herbalist if I start a new medication. I understand the results are not guaranteed.

I understand that all my records will be kept secure and confidential in accordance with federal and state guidelines, and that my records and other information will not be disclosed or released without my written consent.

I hereby assume any and all risk of injury to myself and others in my care. I further release, waive and discharge the herbalist and Tonic, LLC from any and all liability from any loss or damage, even injury resulting in death, whether caused by the attending herbalist's negligence or otherwise.

I will indemnify and hold harmless the herbalist and Tonic, LLC from any loss, liability, damage, expense or cost, whether caused by the herbalist's negligence or otherwise, and whether claimed by or through the undersigned or others, including costs and attorney's fees incurred or suffered by reason of any claims, demands, actions or suits which may be filed or claimed against the herbalist and Tonic, LLC. I agree to not sue the attending herbalist or Tonic, LLC and will not individually, or for others, or on behalf of minors, bring or prosecute, or in any way aid in the institution or prosecution of any claim or suit against the attending herbalist and/or Tonic, LLC.

References to the undersigned shall also include and obligate the undersigned's spouse, family, children, guests, invitees, heirs, assigns and agents, and all persons claiming by or through the undersigned. References to herbalist and/or Tonic, LLC shall benefit its owners, lessors, officers, employees, agents, successors and assigns.

Signature

Date