

Sacred Garden School Clinical Intake Form

Attending Herbalist: _____

Date of Visit _____

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 & approximate length of time you've 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?

Have you had SARS COVID-19? Have you been vaccinated for SARS COVID-19? If so, which vaccine did you receive and when?

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"/> Bulimia | <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:

- Allergies/Hayfever
- Asthma
- Cough
- Postnasal drip
- Sinusitis
- Stuffy nose
- Dry, hard mucus

- Difficulty breathing
- Shortness of breath
- Fluid in lungs
- Recurrent influenza
- Runny nose
- Clear, thin mucus
- Easy to cough up mucus

- Wheezing
- Bronchitis
- Pleuritis
- Cold
- Tuberculosis
- Yellow/Green mucus
- Other: _____

CARDIO-VASCULAR:

- High blood pressure
- Palpitations
- History of Heart attack
- Hands cold, clammy or dry
- Swelling in ankles/joints

- Low Blood Pressure
- Arteriosclerosis
- History of stroke
- Hands warm, sweaty
- Other: _____

- High cholesterol
- Atherosclerosis
- Congestive Heart Failure
- Varicose Veins

IMMUNE/LYMPHATIC:

- Arthritis (rheumatism)
- Chronic fatigue
- Low-grade fever
- Swollen lymph glands
- Lymphatic congestion

- Autoimmune disorders
- Neuralgia
- Low white blood cell count
- Mononucleosis
- Feel "unclean"

- Fibromyalgia
- Frequently sick
- Injuries heal slowly
- Lyme disease
- Other: _____

SKIN:

- Acne
- Boils
- Bleed or bruise easily
- Dry/itchy scalp or hair

- Easily sunburned
- Eczema and dermatitis
- Psoriasis
- red, burning or flushed skin

- Moles
- Rashes
- Slow wound healing
- Oily, damp scalp or hair

MUSCULOSKELETAL:

- Arthritis (not rheumatoid)
- Backache upper/lower
- Broken bones
- Stiffness in joints

- Mobility restriction
- Broken bones
- Torn ligaments
- Bursitis

- Sprains
- Tendonitis
- Gout
- Other: _____

EARS, NOSE, THROAT,

- Failing vision
- Ear aches
- Sore throat
- Frequent stuffy nose

- Hearing loss
- Ear infections
- Laryngitis
- Difficulty swallowing

- Tinnitus/ringing in ears
- Sore or bleeding gums
- Frequent nose bleeds
- Other: _____

NERVOUS SYSTEM:

- ADD/ADHD
- Anxiety
- Irritability
- Memory loss or changes
- Headaches

- Herpes or shingles outbreaks
- Depression
- Overwhelm
- Mental fog
- Migraines

- Panic attacks
- Obsessiveness
- Numbness
- Stress
- 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*

- Anger
- Joy
- Sadness
- Grief
- Worry
- Irritability
- Fear
- Melancholy
- Restlessness
- 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:

Sacred Garden School, 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 Sacred Garden School, LLC, and its students, 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 students, owners and/or employees of Sacred Garden School, 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 & Sacred Garden School, 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 & hold harmless the herbalist and Sacred Garden School, 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 Sacred Garden School, LLC. I agree to not sue the attending herbalist or Sacred Garden School, 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 Sacred Garden School, 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 Sacred Garden School, LLC shall benefit its owners, lessors, officers, employees, agents, successors and assigns.

Signature

Date