**Blooming Mountains Holistic Health**
**Client Intake Form**

**Name:**
**DOB:**
**Birthplace & Exact time (If known):**
**Height:**
**Weight:**
**Occupation:** **Do you enjoy your job?**
**How many hours a week do you work?**
**Primary Concern:**

**Secondary Concern:**

**How Long?**

**Have any significant events occurred prior to these conditions?**

**Have you seen a medical doctor? Been given a medical diagnosis?**

**List of medications, herbs and supplements:**

**Do you use any other forms of alternative medicine?**

**Health History:**
Surgeries:
Vaccines:
Antibiotics:
Previous diagnosis:
Recreational drug use:
Ceremonial drug use:
**Family health history:**
Maternal Side: Paternal Side:

Siblings:

What was/is your relationship with your family like? Parents, siblings?

How was your birth? Were you breastfed?
Married?
Have Children? How many? Ages?

In a relationship?
Do your relationships bring you joy?
Have any pets? What kind?

**Diet:**

What did you eat yesterday?
What is your favorite food? Least favorite food?
What flavor do you crave: sweet, sour, salty, bitter, pungent?
Do you have any food allergies?

How many meals a day do you eat?

Do you prefer fewer big meals or frequent small meals?

Do you feel energized or tired after eating?

Have you ever fasted? Tried an elimination diet? Any other specific diets? How did you feel afterwards?

All raw, no gluten, vegetarian, vegan?
Do you find pleasure in eating? In cooking?
Do you practice mindful eating?
Do you consume any of the following: S= sometimes, O= often, N= never

| | | |
|---|---|---|
| Red meat – Source:<br>Poultry – Source<br>Wild Meats<br>Fish – Source<br>Nut milks<br>Beans<br>Soy products<br>Dairy - Source<br>Milk<br>Cheese<br>Goat cheese<br>Eggs<br>Mushrooms – Organic?<br>Butter<br>Margarine<br>Canola, Soy, Corn Oil<br>Olive, Coconut Oil<br>Soda<br>Herbal Tea | Raw fruits<br>Cooked/dried fruits<br>Raw vegetables<br>Cooked vegetables<br>Sugar, white<br>Maple Syrup<br>Honey<br>Artificial sweeteners<br>Raw Sugar<br>Chocolate<br>Baked goods<br>Seeds<br>Rice<br>Grains<br>Packaged Cereal<br>Black/Green tea<br>Juice<br>Beer<br>Liquor<br>Wine | Pasta<br>White bread<br>Whole grain bread<br>White flour<br>Packaged/frozen food<br>Fast food<br>Fried food<br>Eat out<br>Miso<br>Sauerkraut/Kim chi<br>Vinegar<br>Pickles<br>Chips<br>Crackers<br>Ice cream<br>Yogurt<br>Kefir<br>Seaweed<br>Oats |

Do you eat organic?
Do you drink with meals?

**Digestion:** 1= sometimes. 2= often, 3= major concern, P= past concern, NA= not applicable

| | | |
|---|---|---|
| Acid reflux<br>Anorexia<br>Bad breath<br>Bloating<br>Bulimia<br>Constipation<br>Crohn's disease<br>Often forget to eat<br>Anxious or faint if skip meal<br>Tired/ heavy after meal | Diarrhea<br>Diverticulitis<br>Duodenal ulcer<br>Flatulence<br>Gallstones<br>Hemorrhoids<br>Strong appetite, eat regularly<br>Get irritable if skip a meal | IBS<br>Mouth ulcers<br>Parasite polyps<br>Polyps<br>Receding gums<br>Stomach ulcers<br>Ulcerative colitis<br>Can skip meals easily |

**Elimination:** Check if applicable

| | | |
|---|---|---|
| Abdominal pain<br>Blood in stool<br>Mucus in stool<br>Painful defacation | Loose stool<br>Food particles in stool<br>Changes in bowel habits<br>Quick defecation after eating | Pale gray stool<br>Pencil thin stool<br>Stool that floats |

How frequently do you have a bowel movement?

Describe typical color, shape and size of BM:

**Urinary:** Check if applicable

| | | |
|---|---|---|
| Bladder infections<br>Kidney stones<br>Water retention/ edema<br>Excessive urination | Painful urination<br>Lower back pain<br>Dark under eye circles<br>Gout<br>Frequent thirst | Salt cravings<br>Frequent urge to urinate<br>Wake up @ night to urinate<br>Incomplete emptying |

Describe frequency, color and smell of your urine:

Do you drink liquids before bedtime?

**Muscular/ Skeletal:** Check if applicable

| | | |
|---|---|---|
| Arthritis<br>Stiffness<br>Mobility restriction<br>Bursitis | Torn ligaments<br>Sprain<br>Backache, upper/lower | Broken bones |

**Cardio- Vascular:** Check if applicable

| | | |
|---|---|---|
| High blood pressure<br>Palpitations<br>History of heart attack<br>Hands cold, clammy or dry<br>Swelling in ankles or joints<br>Swellings in hands or feet<br>Low blood pressure | Arteriosclerosis<br>History of stroke<br>Hands warm, sweaty<br>High cholesterol<br>Atherosclerosis<br>Congestive heart failure<br>Varicose veins | |

**Respiratory:** Check if applicable

| | | |
|---|---|---|
| Allergies/ Hay fever<br>Asthma<br>Cough<br>Postnasal drip<br>Sinusitis | Difficulty breathing<br>Shortness of breath<br>Fluid in lungs | Wheezing<br>Bronchitis<br>Yellow/ green mucus<br>Pleuritis<br>Tuberculosis |

| | | |
|---|---|---|
| Stuffy nose<br>Dry/ hard mucus | Recurrent influenza<br>Runny nose<br>Clear/ thin mucus<br>Easy to expel mucus | |

Do you smoke? Tobacco: Other:
How long/often?
Method of smoking:

**Immune:** Check if applicable

| | | |
|---|---|---|
| Auto-immune disease<br>Chronic Fatigue Syndrome<br>Fibromyalgia<br>Neuralgia<br>Lupus | Frequent colds<br>Vaccination (recent or reactions)<br><br>HIV<br>Lyme disease | |

**Lymphatic:** Check if applicable

| | | |
|---|---|---|
| Congestion<br>Swollen nodules/ glands<br>Infection | Drainage<br>Breast Lumps<br>Feeling toxic<br>Arthritis (rheumatism) | |

**Skin:** Check if applicable

| | | |
|---|---|---|
| Acne<br>Boils<br>Bleed easily<br>Bruise easily<br>Slow wound healing<br>Dr/ itchy scalp or hair<br>Oily/damp scalp or hair | Easily sunburn<br>Eczema<br>Psoriasis<br>Red, burning or flushed skin<br>Moles<br>Rashes | |

**Ear, Nose, Throat:** Check if applicable

| | | |
|---|---|---|
| Failing Vision<br>Eye floaters<br>Ear aches<br>Sore throat<br>Frequently stuffy nose | Hearing loss<br>Ear infections<br>Laryngitis<br>Difficulty swallowing | Tinnitus/ ringing in ears<br>Sore or bleeding gums<br>Frequent nose bleeds<br>Other: |

**Nervous System:** Check if applicable

| | | |
|---|---|---|
| ADD/ADHD<br>Anxiety<br>Irritability<br>Memory loss or changes<br>Headaches | Herpes or shingles outbreaks<br>Depression<br>Overwhelm<br>Mental Fog<br>Migraines | Panic Attacks<br>Obsessiveness<br>Numbness<br>Stress (1-10)<br>Insomnia |

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

Which emotions do you experience most frequently? O= often, S= sometimes, N= never

| | | |
|---|---|---|
| Anger<br>Irritability<br>Worry<br>Joy | Fear<br>Lethargy<br>Sadness | Melancholy<br>Grief<br>Restlessness |

What makes you happy?

What makes you sad?

What do you like about yourself?

Is there anything about yourself that you would change?

**Endocrine/ Metabolism:** Check if applicable

| | | |
|---|---|---|
| Adrenal fatigue | Hypoglycemia | Elevated blood sugar |
| Diabetes (type 1 or 2) | Metabolic Syndrome | Hypothyroid |
| Hyperthyroid | Overweight, difficulty losing | Difficulty gaining weight |
| Pituitary | Pineal | Other: |

**Reproductive Men:** Check if applicable

| | | |
|---|---|---|
| Libido high<br>Libido low<br>Premature ejaculation<br>Impotence<br>Sexually transmitted disease, type?<br><br>Prostatitis<br>Benign Prostate Enlargement | <br>Difficulty urinating<br>Kidney/ bladder issues<br>Infertility<br>Low sperm count/ motility<br>Other: | |

Have you ever experienced sexual trauma or abuse?

If so, when and for how long?

Are you sexually active? Does your sex life bring contentment?

**Reproductive Female:** Check if applicable

| | | |
|---|---|---|
| Pregnancies<br>Miscarriage<br>Abortions<br>Contraceptive use<br>Types:<br>How long:<br>Fibroids<br>Breast health<br>Lumps:<br>Pain: | Hysterectomy<br>Date:<br>Reason:<br>Ovarian Cysts<br>Endometriosis<br>Painful Intercourse<br>Vaginal Infection<br>Infertility<br>Testing:<br>Drugs:<br>Procedures: | <br>Pelvic Inflammatory Disease<br>Cervical dysplasia<br>Genital Herpes<br>STD<br>Type:<br>Anemia |

**Menstruating Women:** Check if applicable

| | | |
|---|---|---|
| Regular 28 day cycle<br>Irregular Cycle<br>Heavy Menstrual bleeding<br>Spotting<br>Absence of Menses | Ovarian Pain<br>PMS Symptoms | Food Cravings<br>Other: |

Have you ever experienced sexual trauma or abuse?

If so, when and for how long?

Are you sexually active? Does your sex life bring contentment?

**Peri/ Menopausal Women:** Check if applicable

| | | |
|---|---|---|
| Last Menstrual Cycle:<br><br>Hot flashes<br>Triggers:<br><br>Dramatic mood swings<br>Irritability<br>Dry vaginal lining | Osteoporosis<br>Depression<br>Break-through bleeding<br>Brain fog<br>Estrogen replacement therapy | Interrupted sleep |

**Sleep:**

Do you have a regular sleep schedule?

How many hours of sleep do you get on average?

Difficulty falling or staying asleep?

Do you wake feeling rested?

Do you have dream recall?

Do you have a bedtime ritual? A waking ritual?

**Exercise/ Movement:**

What is your favorite form of movement?

Do you exercise/move daily? Weekly?

How often do you get outside?

Do you feel there is anything holding you back from getting the exercise you want?

Do you have a hobby?

Do you have a spiritual practice?

If you could go anywhere on vacation where would it be?

If I had a magic wand and could fix any one thing, what would it be?

**Blooming Mountains Holistic Health**

**ASSUMPTION OF RISK, RELEASE, CONVENANT 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 Meaghan Thompson of Blooming Mountains Holistic Health.

I hereby consent to the performance of an evaluation on me (or on the person named below 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 and 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 Meaghan Thompson of Blooming Mountains Holistic Health is 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, stomachaches, vomiting, headache, diarrhea, rashes and hives. I understand and do not expect a 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 my 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 some herbs may affect medications. I will notify the 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, Meaghan Thompson from any and all liability from any loss or damage, even injury resulting in death, whether caused by the herbalist's negligence or otherwise.

I will indemnify and hold harmless Meaghan Thompson of Ancestral Earth Medicine 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 Ancestral Earth Medicine. I agree not to sue Meaghan Thompson or Bloomint Mountains Holistic Health 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 Meaghan Thompson or Blooming Mountains Holistic Health.

References to the undersigned shall also include and obligate the undersigned's spouse, family, children, guests, invitees, heirs, assigns ad agents, and all persons claiming by or through the undersigned

Signature: _____ Date: _____.