

# Todd Caldecott, Cl.H. RH(AHG) Clinical Herbalist, Ayurvedic Practitioner

## Clinic Intake Form and Health Profile

**PART ONE: PERSONAL INFORMATION**

Name: \_\_\_\_\_ Gender:  Male  Female  
 Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
**Address**  
 Suite/Street: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone number (home): \_\_\_\_\_ (work): \_\_\_\_\_ (cell/pager): \_\_\_\_\_  
 Email address: \_\_\_\_\_ Website: \_\_\_\_\_  
 Employment Status:  Full time  Part Time  Student  Retired  Unemployed  Other \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Children (#/ages): \_\_\_\_\_ Medical doctor: \_\_\_\_\_

*Please complete this questionnaire as thoroughly as possible.*

Where did you hear about this clinic?  
 \_\_\_\_\_  
 \_\_\_\_\_

What are the major health concerns that brought you here today?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When did this condition begin? \_\_\_\_\_  
 \_\_\_\_\_

Are you currently receiving care from any other health professional(s)? (Please provide names)  
 \_\_\_\_\_  
 \_\_\_\_\_

For which condition(s)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you currently using any supplements and/or medications? Please continue on a separate page if necessary.

Medication/supplement or drug?	Name	Brand name	Strength	Dose	Frequency

Do you have any infectious diseases that you know of?  Yes  No

If yes please list: \_\_\_\_\_  
 \_\_\_\_\_

Is there any chance that you are pregnant?  Yes  No

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc)?  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there any reason you cannot ingest herbal remedies prepared in food-grade alcohol?  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever undergone surgery or been hospitalized? (Please provide the date and reason)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any accidents or injuries you have sustained:  
in the last five years:

\_\_\_\_\_  
\_\_\_\_\_

more than five years ago:

\_\_\_\_\_  
\_\_\_\_\_

**Family Medical History**

*Please complete this section only for any family members with particular health problems.*

Relationship	Age (if deceased, age at death)	Health issue
Mother		
Father		
Siblings		
Children		
Grandmother		
Grandfather		
Other:		

**Personal Health Habits**

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_ Weight in your early 20's: \_\_\_\_\_  
Are you a smoker? \_\_\_\_\_ Years? \_\_\_\_\_ Amount? \_\_\_\_\_ Have you smoked in the past? \_\_\_\_\_ When did you quit? \_\_\_\_\_  
Do you use recreational drugs? \_\_\_\_\_ What types? \_\_\_\_\_ How often? \_\_\_\_\_ times/week.  
Do you exercise regularly? \_\_\_\_\_ Frequency? \_\_\_\_\_ times/week Type? \_\_\_\_\_ Duration? \_\_\_\_\_

**Diet**

Do you drink alcohol?  Yes  No If yes, what types? \_\_\_\_\_ How often? \_\_\_\_\_ times/week.  
Do you drink coffee?  Yes  No How often? \_\_\_\_\_ times/week. How much? \_\_\_\_\_ cups/day.  
Do you drink tea?  Yes  No How often? \_\_\_\_\_ times/week. How much? \_\_\_\_\_ cups/day.  
Do you make a point to drink water daily?  Yes  No How often? \_\_\_\_\_ times/week. How much? \_\_\_\_\_ glasses/day.

To the best of your ability, please indicate what you typically eat on a daily basis (please be honest):

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Supper: \_\_\_\_\_

Snacks: \_\_\_\_\_

Do you indulge in sweets and deserts?  Yes  No How often? \_\_\_\_\_ times/week How much? \_\_\_\_\_ servings/day.  
Do you now or have you ever followed a restricted diet? Please describe and indicate when:

\_\_\_\_\_  
\_\_\_\_\_

**PART TWO: HEALTH CONCERNS**

Please check those issues you have experienced in the last 3 months.

**Skin and Hair**

- Rashes
- Poor healing sores
- Hives
- Itching
- Eczema
- Psoriasis
- Pimples
- Acne
- Dandruff
- Hair loss
- Recent moles
- Recent changes in skin texture

Any other noted problems with your skin, nails or hair?

**Head, Eyes, Ears, Nose and Throat**

- Poor vision
- Floaters
- Cataracts
- Glaucoma
- Blurred vision
- Eye pain
- Earaches
- Poor hearing
- Ringing in ears
- Sore throat
- Canker sores
- Cold sores, if yes how often? \_\_\_\_\_ times/year
- Grinding teeth
- Facial pain
- Clicking jaw
- Jaw pain
- Mucous in throat
- Nosebleeds
- Dizziness
- Frequent colds
- Swollen glands

Any other problems with your head, eyes, ears, nose or throat?

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chest/heart pain
- Fainting
- Irregular heart beat
- Cold hands or feet
- Ankle swelling
- Palpations
- Easy bruising
- Varicose veins
- Blood clots
- Breathing difficulties

Any other problems with your heart or circulation?

**Gastro-Intestinal**

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Black stools
- Bad breath
- Indigestion
- Abdominal pain
- Heartburn
- Gas
- Blood in stools
- Mucous in stools
- Rectal pain
- Hemorrhoids
- Bloating
- Food cravings
- Poor appetite
- Gallstones
- Ulcers
- Difficulty swallowing
- Colitis/IBS
- Liver problems

How many bowel movements do you have a day?  <1  1  2  3  4+

How would you describe your bowel movements?  Loose  Normal  Hard  Tarry

Do your stools:  float?  sink?  have a bad odor?  have no odor?  display blood?

Do you rely on:  Enemas  Laxatives or  Purgatives for bowel elimination? If yes, how often? \_\_\_\_\_ times/week

Any other digestive problems?

**Respiratory**

- Hayfever
- Cough
- Bronchitis
- Asthma
- Coughing blood

- Pneumonia
- Pain on breathing
- Shortness of breath without exertion
- Difficulty breathing when lying down
- Production of phlegm, if yes what color? \_\_\_\_\_

Any other problems with breathing?

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**Genito-urinary**

- Painful urination
- Frequent urination
- Blood in urine
- Urgency of urination
- Kidney/bladder stones
- Irregular flow
- Inability to hold urine
- Decrease in flow
- Water retention

- Burning urine
- Difficulty stopping or starting
- Prostate enlargement
- Interstitial cystitis
- Prostate enlargement
- Erectile dysfunction

Any other problems with urination?

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**Musculoskeletal**

- Neck pain
- Muscle pain
- Stiffness
- Back pain

- Muscle weakness
- Broken bones
- Reduced range of movement

Do you see a Chiropractor or Massage Therapist? (Please provide name).

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Any other musculoskeletal problems?

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**Female reproductive**

- Discharge, if yes what is the color? \_\_\_\_\_
- Genital herpes
- Cervical dysplasia
- Endometriosis
- Uterine cysts
- Fibroids
- Vaginal itching
- Anemia

- Pelvic inflammatory disease
- Infertility
- Hysterectomy
- Pain with intercourse
- Tubal ligation
- Mastectomy
- Lumpectomy
- Vaginal infection

Do you menstruate?  Yes  No

If yes, what is the length of your cycle (period to period): \_\_\_\_\_ days, and the duration of bleeding \_\_\_\_\_ days?

Would you characterize your flow as:  Heavy  Normal  Light? Is the blood:  Dark  Normal  Light?

Do you have premenstrual symptoms (PMS)?  Yes  No

How many days before your cycle do symptoms begin to manifest? \_\_\_\_\_ days before period

**Female reproductive (continued)...**

If you have PMS, which symptoms apply to you?

- Anxiety
- Nervousness
- Mood Swings
- Nervous tension
- Craving for sweets
- Increased appetite
- Palpitations
- Fatigue
- Dizziness
- Headaches
- Breast tenderness
- Bloating
- Weight gain
- Water retention
- Depression
- Poor memory
- Grief
- Confusion
- Insomnia
- Lower back pain
- Abdominal pain
- Joint pain
- Headaches

Do you have breast implants?  Yes  No If yes, are they:  Silicon  Saline  Other

If yes, have you noted any problem with them?  Yes  No

Date and result of last PAP smear: \_\_\_\_\_

How many: pregnancies have you had? \_\_\_\_\_; births? \_\_\_\_\_; miscarriages? \_\_\_\_\_; premature births? \_\_\_\_\_; abortions? \_\_\_\_\_

Do you or have you recently used contraceptives?  Yes  No

If yes, which ones?

- IUD  Condoms  Diaphragm  Rhythm  Mucous method  Spermicidal jelly
- Other (please describe): \_\_\_\_\_

Are you post-menopausal?  Yes  No

If yes, when was the approximate date of your last period?

If you have menopausal symptoms, please describe your major symptoms:

\_\_\_\_\_

Do you have any other gynecological issues?

\_\_\_\_\_

**Neuropsychological**

- Poor sleep
- Poor memory
- Numbness, if yes, where? \_\_\_\_\_
- Depression
- Irritability
- Anxiety
- Seizures
- Migraine
- Headaches
- High stress levels
- Loss of balance
- Lack of coordination
- Difficulty concentrating
- Foggy or spacey feeling
- Muscle spasm/twitching

How many hours do you sleep each night? \_\_\_\_\_

Do you have any other neurological problems?

\_\_\_\_\_

**Metabolic**

- Chronic fatigue
- Fevers
- Chills
- Night sweats
- Excessive thirst
- Slow metabolism
- Sudden energy drops
- Intolerance to heat or cold
- Recent weight gain
- Recent weight loss

Any other health concerns or problems?

\_\_\_\_\_

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins encountered beyond what might be expected in one's day to day life?

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**Mind and emotions**

How do you feel about the following areas of your life? Please check appropriate boxes and make any comments you would like to

	Excellent	Good	Fair	Poor	Comments
Self					
Spouse/Partner					
Sex					
Family					
Life purpose					
Finances					

Are you able to express your feelings and emotions easily?  Yes  No

Is there an excess of stress in your life?  Yes  No If yes, what is causing you so much stress?

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Do you have tools or techniques to relieve stress?  Yes  No

Are you satisfied with your current living/working environment?  Yes  No

If there is one thing in your life that you would like to change right now, what is it?

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Are you a 'nervous type' person?  Yes  No If yes, what things make you most nervous?

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Do you sleep well?  Yes  No

What feelings do you most often experience in your life?

joy  happiness  anger  sadness  fear  anxiety  sympathy  worry  depression

**Vision Statement**

What is your desired goal for your visit to this clinic?

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**Waiver of Liability**

I, the undersigned, hereby confirm that I am consulting with Todd Caldecott of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that Todd Caldecott will offer an assessment of my general health and will make dietary, herbal and nutritional recommendations to support my health. I understand the importance of frequent monitoring to revise the treatment protocol as required.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Print name: \_\_\_\_\_

*All case history notes and medical information recorded during the consultation are kept strictly confidential. Information contained herein will not be released to any person or agency except with your authorization or where required by law.*