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
__Palpitations
__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?

_____

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
__Erectile dysfunction

Any other problems with urination?

_____

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).

_____

Any other musculoskeletal problems?

_____

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?

_____

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?

_____
_____

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?

_____
_____

Are you a 'nervous type' person? __Yes __No If yes, what things make you most nervous?

_____
_____

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?

_____
_____

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.