Spring to Health
APOTHECARY

Spring to Health Apothecary

HERBAL CONSULTATIONS

900 S Main Street, St 355, Keller, Texas, 76248, springtohealthapothecary@gmail.com
682-593-0783

Herbal Intake Form

Personal Information

(Please print clearly)

Name:

_____

Address:

_____

_____

Telephone: (w)_____ (h) _____
Best time(s) to call:

Email:_____

Occupation: _____

Gender (m/f): _____ Age: _____ Height: _____ Weight: _____lbs

Marital status: _____Birth date: _____

Number of children: _____ Age(s): _____

Please list all physicians and other healthcare providers or consultants (such as Acupuncturist, massage therapist, etc) you see on a regular basis:

Name	Location	Type of Service
_____		

_____

_____

_____

_____

Family Medical History:

Please describe any relevant or major health-related issues:

Father: _____

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Other family members with pertinent issues, or recurring family health trends:

_____

_____

PRESENT HEALTH STATUS

Do you currently smoke tobacco (y/n)? _____

If so, how many cigarettes/day? _____

If not, have you ever been a smoker in the past (y/n)? _____

For how many years did you smoke? _____When did you quit? _____

Do you currently drink alcohol (y/n)? _____
If so, list type, quantity, and frequency: _____

Did you consume alcohol in the past (y/n)? _____ When did you quit alcohol? _____
If so list type, quantity and frequency:_____

List form and frequency of any regular exercise: _____

How is your digestive system overall, do you experience indigestion, gas, constipation, diarrhea, bloating or other? _____

_____

How often do you have a bowel movement? _____

How often do you urinate and what is the character of your urine, i.e., light, dark, strong odor?

_____

Present Health Status

Check each column where symptoms apply and elaborate in space provided below if necessary. Please indicate with a √ any experiences below that you sometimes experience; two checks √√ for those which occur often; and use three checks √√√ for those which are a major concern.

Cardiovascular

_____High Blood Pressure
_____Low Blood Pressure
_____Pain in Heart
_____Poor Circulation/cold extremities
_____Swelling in Ankles/joint
_____Previous heart stroke/murmur
_____High Cholesterol

Muscles/Joints

_____Backache/upper or lower
_____Broken Bones
_____Mobility Restriction
_____Arthritis/Bursitis

Skin

_____Boils
_____Bruises
_____Dryness
_____Itching
_____Varicose Veins
_____Skin eruptions

Respiratory

_____Chest Pain
_____Difficulty breathing
_____Cough
_____Tuberculosis
_____Congestion

Eyes, Ears, Nose, and Throat

_____Asthma
_____Ear Aches
_____Eye Pains, Dry/Wet
_____Failing vision
_____Hay Fever
_____Sinus Infection
_____Sinus Congestion
_____Sore Throat
_____Tonsils
_____Hearing Loss/Ringing Ears

Urinary/Kidney

_____Excessive Urination
_____Water Retention
_____Burning Urine
_____Kidney Stones
_____Lower Back Pain
_____Dark circles under eyes
_____Itchy Ears/eyes
_____Emotional Insecurity

Gastro-Intestinal

_____Belching
_____Colitis
_____Constipation
_____Abdominal Pain
_____Liver Problems
_____Gall Stones
_____Ulcers
_____Indigestion

Sleeping Patterns

_____Insomnia
_____Waking in the night
_____Nite sweats
_____Restless sleep
_____Wake up tired
_____Difficulty falling back to sleep

Miscellaneous

_____Usually feel Hot/Warm
_____Usually feel Cold/Cool

Common Physical Activities

__Desk Sitting (how long)
__Sitting in a car (how Long)
__Jogging/Running
__Calisthenics
__Aerobics
__Swimming
__Weight Lifting
__Walking
__Other_____

__Standing (how long?)
__Yoga
__Tai Chi
__Hiking
__Bike Riding
__Horseback Riding
__Tennis
__ Bending/Lifting

Do any of the conditions above aggravate a current health condition?

Have you had any operations? What year? _____

Any major injuries/accidents? What and when? _____

Any major illness or hospitalizations? What and when? _____

DIETARY INFORMATI ON

Please check each item listed below if it is included in your daily - or usual - diet:

__Red Meat
__Fish
__Poultry
__Fruits
__Vegetables
__Raw Foods
__Grains
__Nuts
__Seeds
__Fermented Foods

__Butter
__Milk
__Cheese
__Yogurt
__Sugar
__Honey
__Baked Goods
__Deserts
__Chips
__Crackers

__Candy bars/chocolate
__Coffee
__Black Tea
__Herbal Tea
__Alcohol
__Vitamins
__Protein Supplements
__Food Supplements
__Processed foods/snacks

Dietary Information

Describe below your typical meals. Please be as specific as possible. For example,
Instead of "oil" list type of oil, such as olive, corn, etc.
Instead of "bread" list whether white or whole grain, etc.
Instead of "vegetables" list type of vegetable, how prepared, canned, frozen, or fresh, etc.
Please include beverages, type and quantity (two cups of coffee, one glass of orange juice, etc.)

Breakfast: _____

_____

A.M. snack(s): _____

Lunch: _____

_____

P.M. snack(s): _____

Dinner: _____

_____

Evening snack(s):
_____

Daily water consumption (# glasses/quantity/day): _____

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.): _____

_____

Please list any known food allergies/sensitivities (attach additional sheets if needed):

Food	Describe Reaction
_____	
_____	
_____	
_____	

Current State of Emotions and Feelings

Please take a moment to answer the following questions:

Are you able to express your feelings and emotions?

Is there an excess of stress in your life?

What is causing the Stress?

Are you satisfied with your job?

If in a relationship, are you satisfied with it?

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

Can you change it?

Are you a "nervous type" person? What are the things that make you most nervous?

Have you a "super woman/superman" complex?

Do you sleep well?

Do you dream? Do you remember your dreams?

Are you satisfied with your general energy level?

Do you often feel exhausted and fatigued?

Is it easy to wake up in the morning?

Which of these feelings dominate in your life: joy happiness anger sadness fear sympathy worry depression

If you were to choose one or two Emotions, which seem predominant in your life they would be_____and_____

Please indicate approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residents, injury, death, etc.)

Year Event

Supplements and Medications

List all herbs, vitamins, and dietary supplements you currently take,
Citing brand name whenever possible: list dosage Use additional space on back if needed

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_____

List all medications you are currently taking and ***what they are taken for***
(including aspirin, antacids, etc.),
indicating whether they are over the counter (OTC) or prescription (P):
Use additional space on back if needed

Name of Product/used for OTC or P? Dosage Frequency (#/day)

_____

_____

List all medications, herbs, etc., to which you have a known allergy:

_____

What are the areas of current complaint that you would like to address with an herbal program?

_____

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STATEMENT OF UNDERSTANDI NG

Only a physician (MD) can diagnose, treat, and prescribe medicines for illness or disease. As an herbalist and not an MD I neither diagnose nor treat disease. Neither do I prescribe remedies.

The human body has the innate power to heal itself. Without this power to self-heal, even the most advanced medications and surgical procedures would ultimately fail. The role of the herbalist in this healing process is to consider the client as a whole person and to consult with the client concerning changes in lifestyle, diet, and supplementation of herbs and/or vitamins to foster an increased state of balance and health. Thus maximizing the body's self-healing capabilities.

I encourage and advise clients to seek professional medical advice regarding any illness or disease they are suffering from. Background health information can aid in the process of a holistic, herbal program and therefore can be shared at the time of the herbal consultation. Any concerns about your health and supplementation with herbs or diet should be done in consultation with your doctor.

Sophia Qadri, Herbalist
Spring to Health Apothecary

Please sign below once you have read and understood the above statement:

Name (print)_____Date: _____

Signature_____

Witness Name (print):_____Date:_____

Signature_____

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