Hummingbird Healing Oils
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Personal Intake Form

This information is confidential. (See confidentiality policy.)
Client Name

Gender (M, F)

Address

City State Zip

Daytime Phone Alternate Phone

Birthdate Height Weight

Occupation Email

What is the main reason for your visit today?
When did the symptoms begin?
What precipitated or started the condition?
Does anything make it better or worse? Such as time of day, heat or cold, season of the year, emotions, motion or position? Is it worse on one side of the body?

Are there any other areas of well-being you are interested in addressing?

How would you rate your overall health today (1-10; 1=poor, 10=excellent)

Are you under the care of a physician? Yes ☐/No ☐
Who is your physician? (List all you think appropriate: MD, acupuncturist, chiropractor, etc.) with phone number if possible.
When was your last physician visit?
When was your last gynecological exam?
Please list any diagnosed medical problems

What medications are you currently taking? Please include the full names of prescriptions, over-the-counter drugs, herbs, and vitamin supplements, along with their dosage, and correct spellings.

Have you ever experienced an adverse effect to a drug? If Yes, which one/s?

To an herb or herbal medicine?

Do you have any allergies?

Do you prefer hot or cold beverages?

What gives you joy?

Are you experiencing any of the following:

☐Pain Describe

☐Fever ☐Vomiting

☐Diarrhea

☐Unusual color of bowel movement (dark/light/blood)

☐Frequent urination ☐Blood in urine

☐Night sweats ☐Depression with thoughts of suicide

☐Unusual shortness of breath ☐Edema

☐Unusual abdominal bloating ☐Numbness, tingling, or paralysis

☐Recent fainting or loss of consciousness ☐Lumps, swellings, sore lymph nodes

☐Bleeding of any kind ☐Unusual or persistent fatigue

☐Sudden changes in sense perceptions, memory, speech?

☐Erectile dysfunction

Have you or anyone in your family ever had?

	Self	Family	Relationship
Diabetes	☐	☐	
Glaucoma	☐	☐	
Thyroid problems	☐	☐	
High blood pressure	☐	☐	
Heart trouble	☐	☐	
Stroke	☐	☐	

Cancer or tumor		☐	☐
Tuberculosis		☐	☐
Emphysema		☐	☐
Ulcer		☐	☐
Arthritis		☐	☐
Allergy/Asthma		☐	☐
Food Intolerance/allergy		☐	☐
Kidney/bladder problems		☐	☐
Mental Illness		☐	☐
Osteoporosis		☐	☐
Addiction/alcoholism	☐	☐	
Eating Disorder		☐	☐
Toxic or chemical exposure		☐	☐

Medical History

Childhood illnesses with date/age:

Adult illnesses with date/age:

Psychiatric illness or emotional trauma with date/age:

Car accidents with date/age:

Injuries and/or traumas with date/age:

Please list any surgeries and/or hospitalizations you have had, and their DATE.

Social and Emotional History

What is your living situation?

Significant others?

Sexual history?

What is your occupation?

What are your Spiritual Beliefs?

What is your present outlook on life?

Diet

What do you normally eat for breakfast?

Best breakfast?

Worst breakfast?

Best lunch?

Worst lunch?

Best dinner?

Worst dinner?

What do you like to snack on?

What is your favorite food or foods?

If you were allergic to a food, what would it be?

How much do you smoke? per day per week

How much alcohol do you drink? per day per week

How much coffee do you drink? per day per week

Soft drinks? per day per week

Regular ☐or diet? ☐

Chocolate? per day per week

Water? # of 8oz glasses per day

Tap? bottled? filtered?

How much do you exercise

Run/cycle/swim/dance/aerobics	minutes per day	days per week
Walk/hike	minutes per day	days per week
Resistance exercise	minutes per day	days per week
Other exercise	minutes per day	days per week

How much sleep do you get at night? hours

Do you wake up rested? Y ☐N ☐ Sleepy or fatigued during the day? Y ☐N ☐