INTAKE FORM - ADULT DATE:

NAME: _____

DATE of BIRTH: _____

GENDER: F / M

REFERRED BY:

_____

YOUR CONTACT INFORMATION:

Address _____ **City** _____ **Postal Code** _____

Telephone h) _____ **w)** _____

Email _____

EMERGENCY CONTACT PERSON:

Name _____ **Relationship** _____

Telephone h) _____ **w)** _____

CURRENT HEALTH CONCERNS (please list in order of importance)

-
-
-
-

LIST ANY SERIOUS ILLNESSES, INJURIES or HOSPITALIZATIONS (please provide dates)

-
-

ANY KNOWN ALLERGIES (please list)

-
-

CURRENT MEDICATIONS / SUPPLEMENTS (please list those in current use)

-
-
-

YOU ARE CURRENTLY: **Meat eater** **Vegetarian** **Other**

CHILDHOOD DISEASES (please circle)

MUMPS **MEASLES** **RUBELLA** **CHICKENPOX** **PNEMONIA**

WHOOPING COUGH **OTHER:**

VACCINATIONS (please circle all that are appropriate)

DPT (diptheria, pertussis, tetanus) **MMR** (measles, mumps, rubella) **POLIO** **OTHER:**

MAJOR HEALTH PROBLEMS OF BLOOD RELATIVES: (please note as appropriate)

Mother **Father** **Grandparents** **Siblings**

ARE YOU CURRENTLY UNDER THE CARE OF OTHER HEALTH CARE PROFESSIONALS? If yes, please note the care that is currently being provided.

HEALTH CARE PROFESSIONAL	CONDITION/S	TREATMENT/S
▪		
▪		
▪		

ADDITIONAL COMMENTS:

INFORMED CONSENT

I acknowledge that I am responsible for the decisions made related to my health. I intend to make the best decisions on my behalf based upon the information that I gather. I have provided full disclosure related to my health concerns.

I acknowledge that I have sought the professional services of Danette Steele, M.A., RH (OHA), Registered Clinical Herbalist, on my behalf and that I will take into consideration the recommendations and suggestions that she makes. I agree to fully discuss the proposed herbal treatment plans with Danette Steele to my satisfaction.

Name:

_____

Signature:

_____

Date:

_____