Vermont Center for Integrative Herbalism Community Clinic

New Client Questionnaire

Please answer the questions below as thoroughly as possible to assist us in making the best possible clinical assessment.

Please allow 30-45 minutes to complete this questionnaire.

Name_____ Today's Date _____

Address_____

Telephone Day_____ Night_____ Email:_____

Emergency Contact: _____ Best way to contact you:_____

Date of Birth _____ Age_____ Gender: _____ Pronoun _____ Height & Weight _____

What are your primary goals in working with an herbalist?

1._____

2._____

3._____

What other health-related issues do you have/have you had in the past?

_____

_____

_____

Please list any other practitioners you are currently working with.

_____

Medications currently or previously used (over the counter and prescription):

Medication	Dosage/Frequency/Taking how long?	For what reason are you taking this?

Please feel free to attach a separate list or continue on the back if you are taking more medications than the space available permits you to list.

Supplements/vitamins/herbs currently used:

Supplement (include brand)	Dosage/Frequency/Taking how long?	For what reason are you taking this?

Family Health History

Relationship	*Alive/Deceased*	*Present health or cause of death*
Father		
Mother		
Brothers		

Sisters _____

Children/ages _____

_____

_____

Have you or any blood relatives had any of the following? (Circle those that apply to family members, check those that apply to you.)

☐ Allergy/Asthma	☐ Headaches/Migraines	☐ Obesity
☐ Arthritis	☐ Heart Disease	☐ Stroke
☐ Bleeding/Clotting Disorder	☐ High Blood Pressure	☐ Substance abuse
☐ Cancer--type:	☐ Kidney Disease	☐ Thyroid Disease
☐ Diabetes	☐ Liver Disease	☐ Tuberculosis

Diet:

Please check boxes and indicate how often you consume the following (daily, weekly, monthly, etc).

❍ Dairy products	❍ Beans	❍ Eggs
❍ Soft drinks	❍ Soy products	❍ Alcohol
❍ Margarine	❍ Fish	❍ Fried foods
❍ Butter	❍ Chicken, turkey	❍ Tobacco
❍ Nuts & Seeds	❍ Vegetables	❍ Coffee
❍ Fruits	❍ Red Meat	❍ Bakery goods
❍ Greens (kale, collards, etc.)	❍ Water	❍ Chips/crackers/pretzels

Please estimate the percentage of food you buy from the supermarket _____; healthfood store_____; farmer's market_____

How often do you eat at restaurants? _____ How often do you cook/prepare food? _____

How many meals do you eat a day? _____ How often do you snack and when?_____

What foods do you crave?_____

Do you follow or have you ever followed a restricted diet? Which one(s)? _____

_____

List any food(s) that your are allergic or sensitive to._____

Please indicate an example of (1) your diet when you have time and energy to prepare meals and (2) a typical diet when stressed or pressed for time. Please include beverages.

(1) : Breakfast	**Lunch**	**Dinner**	**Snack (time of day)**
(2): Breakfast	**Lunch**	**Dinner**	**Snack (Time of day)**

General Health Questions:

Education: _____ Passions/Interests: _____

Occupation _____ How long? _____ Previous occupations: _____

Where and when have you lived or traveled outside the U.S. and Canada? _____

_____

Are you allergic or sensitive to any substance (medications, pollens)? _____

Have you had any surgeries? _____ For what reason(s)? _____
Describe any complications: _____
Have you had lengthy exposure to environmental toxins (work w/chemicals? home near polluted area)? _____
_____
Highest weight as an adult: _____ Year: _____ Lowest weight as an adult: _____ Year: _____
Typical hours spent watching TV per day _____ Typical hours on the computer per day _____
Exercise –type/frequency/for how long_____ _____
Typical bedtime _____ Typical hours asleep _____ Do you feel rested upon waking? _____
Relationship Status: _____ Are you satisfied with your primary relationships and/or your support system?_____
_____
Are you currently sexually active? _____ If applicable, are you using any safer sex methods (i.e. condoms /dams) or birth control methods (i.e. IUD, patch/ring, fertility awareness)? _____
_____
Are you now pregnant? _____ Are you currently breastfeeding? _____
Are you or your partner actively trying to conceive? _____ For how long? _____

*** If you discover that you are pregnant during the course of our work together, please discontinue all herbal supplements until we can discuss whether your recommendations need to be modified ***

On a scale from 1 (low) to 10 (high), how stressful is your: Work? _____ Health status? _____ Social/family situation? _____
Are you satisfied with your energy levels? Yes Sometimes No
What would you describe as the dominant emotions in your life right now? (joy, worry, satisfaction, anger, fear, inspiration, etc.)

Please check anything you have experienced in the past year. Any issues that you had previously, but no longer have, mark with a "P".

__ Abnormal Pap	__ Frequent cold sores	__ Nausea	__ Sinus Infections
__ Bruise easily	__ Frequent diarrhea	__ Night sweats	__ Shingles
__ Breast lumps/fibroids	__ Frequent gas	__ Nose bleeds	__ Skin rashes
__ Chemical sensitivity	__Gum problems	__ Numbness	__ Swollen glands
__ Chest pains	__ Hearing issues	__ Ovarian cysts/PCOS	__ Tinnitus (ringing in ears)
__ Chronic fatigue	__ Heart palpitations	__ Painful intercourse	__ Ulcers
__ Depression	__ Heartburn/GERD	__ Phobias	__ Urinary tract infection
__ Digestive issues	__ Hysterectomy / oophorectomy	__ Prostate pain	__ Uterine fibroids
__ Earaches	__ Incontinence	__ Poor concentration	__ Vaginal dryness
__ Eczema/Psoriasis	__ Low libido	__ Respiratory issues	__ Vasectomy
__ Endometriosis	__ Lyme Disease	__ Sexually transmitted infection	
__ Fainting	__ Memory Loss	__ Seizures	

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In each row, please read across the three columns and circle the box(es) that best describe you. You may circle more than one box per row.

General	Variable energy	Consistent high energy	Slow to start, but steady energy
	Tendency toward being cold	Tendency toward being warm	
	Love to travel	Action oriented	Love to stay home
	Lose weight easily	Maintain weight easily	Gain weight easily
	Variable sleep	Deep, but short sleep	Deep sleep
	Wake easily	Generally wake refreshed	Generally waking is difficult
	Love privacy	Love risk and adventure	Love affection and approval

Mind	Live in future	Live in present	Live in past
	Creative, Visionary	Bold, Courageous	Calm, Resilient
When stressed, tendency toward	Fear/anxiety	Quick to anger	Despondency
	Difficulty focusing	Focused mind	
	Emotions difficult to control	Controlled emotions	Not much variance in emotions
	Need solitude when stressed	Need action when stressed	Need people when stressed
Memory	Good short-term; poor long-term	Detail oriented	Good long-term; poor short-term
Renal/Bladder	Frequent dizziness on standing/ low blood pressure		
	Frequently thirsty (fluids "run right through")	Hot weather aggravates urinary symptoms	Infrequent thirst
	Urgent need to urinate when nervous	Infrequent urination in hot weather	
	Urine almost always clear	Urine usually yellow	Urine often cloudy
	Frequent urination		Urinate infrequently; large volume
	Prefer moist environment		Prefer dry environment
	Crave salt		Feel worse when using salt
Respiratory	Respiratory tract easily irritated by dry air		Respiratory tract feels better with spicy food
	Respiratory tract easily irritated by smoke/irritants	Respiratory symptoms worse in hot air/environments	Respiratory symptoms worse in cool/damp air
	Nasal passages often feel dry	Respiratory tract feels inflamed ("hot, burning, irritated")	Nasal passages or sinuses feel full or swollen
	Shallow breather		Infection tends to settle in lungs
	Hyperventilate/forget to breathe when stressed	Frequent yellow or green mucus	Frequent clear/white mucus
Menses	Menses irregular	Menses predictable	Constipation before menses
	Sharp, stabbing cramps	Loose stools with menses	Pressing, dull, aching cramps
	Fatigue with menses		Water retention before menses
	Menses starts with red blood		Menses starts with brown blood/spotting
Skin	Skin is cool & dry	Skin is warm & moist	Skin is cool & moist
	Skin is thin & flaky	Skin is firm	Skin is soft & smooth
	Dry hair & scalp	Thin hair, tends toward oily, may have receding hair line	Thick, shiny hair
	Lips chap easily		
	Nails brittle/cracked	Soft, flexible nails	Strong, thick nails
	Skin is worse in winter	Skin is worse in summer	Skin is worse in damp
		Skin is red & easily inflamed	
Digestion	Variable appetite	Strong, demanding hunger	Predictable appetite
	Dry, pebbly stools	Loose and regular stools	Sluggish or regular bowels
	Alternating constipation/diarrhea	Burning sensation after eating	Feel heavy/stuck after eating
	Frequent gas, painful	Yellowish/light brown stools	Foul-smelling gas

	Often forget to eat	Think of food as fuel to keep going	Eat to calm down
	Difficulty digesting heavy foods	Strong digestion	
	Need to eat frequently		Feel good on only one or two meals a day
	Quick defecation after eating		
Cardiovascular	Rapid, erratic pulse	Strong pulse	Slow pulse, steady
	Cold hands & feet	Feels warm/ hot most of the time	Tendency toward edema, swelling
	Difficulty adjusting to temperatures		
	Heart palpitations when stressed		
	Frequent low blood pressure	Tendency to high blood pressure	
Immunity	Complete exhaustion when ill	Attempt to work through illness	Take time off for slightest hint of illness
	Recuperation from illness variable	Recuperate quickly after illness	Recuperate slowly after illness
	Inflammation comes and goes	Easily inflamed, resolves quickly	Inflammation resolves slowly
	Arthritis/rheumatism worse with cold	Arthritis worse with heat	Arthritis/rheumatism worse with cold/damp

Please list major events in the last ten years of your life (or further back if it seems significant) and the dates they occurred. Include events such as births, deaths, marriages, divorces, accidents, moves, jobs changes, miscarriages, illnesses and anything else you feel greatly impacted your life.

Date Event

Anything additional that you'd like to mention related to health and well-being: