HOLISTIC CLINIC
**Anju Prasad - Ayurvedic Practitioner**
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**INTAKE FORM**

Date: _____/_____/_____

Last name: _________________ First Name: ________________ Middle Name: _________

Date of Birth: _____/_____/_____ Sex: M F Height: __________ Weight: _________

Address: __________________________________ City: ___________________________

Province: ____________ Postal Code: _____ - _____ Email: _________________________

Daytime Phone number: (___) ______ - _____ Evening phone number: (___) _____-_____

Emergency contact: ___________________________ Relationship: ___________________

Name of present MD: ________________________________ Phone: (___) _____ - ______

Date of last medical doctor visit: ________________ Date of last physical exam: __________

Do you get periodic check ups by another doctor (Pap, blood tests, etc...)? Yes / No

How did you hear about Anju's Herbals ? _____________________________________

What are your health issues, in order of relevance to you:

1. ______________________________________________________________________

2. ______________________________________________________________________

3. ______________________________________________________________________

4. ______________________________________________________________________

5. ______________________________________________________________________

If you are a female, are you presently pregnant? Yes / No

**Medical Health of Patient:**

Please verify item(s) which concern you **today or did in the past**:

| | | |
|---|---|---|
| O Asthma | O Constipation | O Anxiety / Depression |
| O Diabetes | O Diarrhea | O Headaches |
| O Arthritis | O Allergies | O Heartburn |
| O Cancer ____________ | O High Cholesterol | O Other _________________________ |

**Past Childhood Illnesses:**

| | | | |
|---|---|---|---|
| O Asthma | O Chicken pox | O Whooping cough | O Measles |
| O Rheumatic fever | O Polio | O Mumps | O Tuberculosis |
| O Rubella (German measles) | O Scarlet fever | O Roseola | O Other _________ |

Other: _________________________________________________________________

**Vaccinations:**

| | | |
|---|---|---|
| O DPT (Diptheria Pertussis, Tetanus) | O BCG (Tuberculosis) | O Pneumococcal Conjugate (Meningitis/pneumonia) |
| O MMR (Measles, mumps, rubella) | O Hepatitis A | |
| O Gardasi/Cervarix (HPV Vaccine) | O Hepatitis B | O Meningococcal C Conjugate (Meningitis) |
| O Haemophilus Influenza B | O Flu Vaccine | |
| O Varivaz/Varilrix (Chicken Pox) | O Polio | O Other _______________ |

Any reactions to the vaccines, and if so, what kind? ___________________________________

**Current Medications and Nutritional Supplements:**

Any antibiotics? Y / N Total number of antibiotics: ______________

1.) Medication: _______________ For: _________________ Start Date: ______________

Duration of time on drug: _________________ Reactions to drug? ____________________

2.) Medication: _______________ For: _________________ Start Date: _______________

Duration of time on drug: _________________ Reactions to drug? ____________________

3.) Medication: _______________ For: _________________ Start Date: _______________

Duration of time on drug: _________________ Reactions to drug? ____________________

4.) Medication: _______________ For: __________________ Start Date: ______________

Duration of time on drug: _________________ Reactions to drug? ____________________

**Supplements/ Vitamins:** (Minerals, herbs etc….):
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

**Do you often use any of the following?**

O Aspirin
O Laxatives
O Antacids
O Diet pills
O Birth Control/injections/implants?
O Recreational drugs – what and how often ________________________________________
___________________________________________________________________________

O Alcohol, how many drinks per day/ week? ____________________
O Tobacco – amount/day? ________ How long? ______Type? _____
O Caffeine – cups of coffee/tea per day? ______________________

**Past Hospitalizations:**
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

**Past Surgeries:**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Family Medical History:**

Please indicate by noting **M** (mother), **F** (father), **S** (sibling), **PGM** (paternal grandmother), **MGM** (maternal grandmother), **PGF** (paternal grand father), **MGF** (maternal grandfather)

Allergy, asthma or eczema ____________Liver Disease ____________ Cancer ___________
Arthritis ___________ Diabetes or low blood sugar ____________ Mental Illness ________
Heart Disease _________ Lung Disease __________ High Blood Pressure/stroke _________
Kidney Disease ________ Other: _____________________________________________
______________________________________________________________________
______________________________________________________________________

**Diet & Lifestyle Habits:**

Do you have any food allergies or intolerance? Please list.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Do you have any dietary constraints (religious, vegetarian, vegan etc...)?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Describe your daily diet:

Breakfast ______________________________________________________________
Lunch _________________________________________________________________
Dinner ________________________________________________________________
Snacks ________________________________________________________________
Beverages (and total quantity) ______________________________________________

Occupation ______________________________ Hobbies ____________________________

Do you have problems falling asleep? Y / N
Explain: ___________________________________________________________________

Do you exercise? Y / N If yes, how many hours per week? ______________________

How old is your dwelling? ____________________ How is it heated? ____________________

Is it located near: O trees O powerlines O highway O industry O other: _____________

Are you frequently exposed to toxins or other hazards (work, home, hobbies, etc...)?

____________________________________________________________________________

How is the emotional environment at home?

____________________________________________________________________________

How stressful is your work, or other facets of your life? How do you cope with these stresses?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**General Review of Systems:**

Do you have any rashes, lumps, sores, itching, dry skin, change in hair or nails? Y / N

If yes: _____________________________________________________________________
____________________________________________________________________________

Have you ever been unconscious, had a convulsion, have recurring headaches or had a head injury? Y / N

If yes: _____________________________________________________________________
____________________________________________________________________________

Any problems with hearing, ringing in the ears, dizziness, ear infections, discharge? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Any problems with the eyes, including vision? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Any problems with teeth, gums, tongue, sore throats or hoarseness? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Have you ever had a cough, wheeze, or asthma? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Any recurring problem with vomiting, diarrhea, constipation or stomach pain? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Any usual problem on passing urine or any unusual frequency? Any unusual smell or appearance to the urine? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Do you complain of any extremity or lower back pain? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Have you had any blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tremors, or other involuntary movements? Y / N

If yes: ________________________________________________________________
__________________________________________________________________________

Do you have thyroid trouble, excessive thirst or hunger, heat or cold intolerance, or diabetes? Y / N

If yes: ___________________________________________________________________
____________________________________________________________________________

Any allergies, eczema, hay fever, hives, or drug interactions? Y / N

If yes: ___________________________________________________________________
____________________________________________________________________________

Do you have any intense fears, mood swings, or other sensitivities? Y / N

If yes: ___________________________________________________________________
____________________________________________________________________________

**OTHER – Health Concerns & Additional Information:**

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**Appointment Time:**

_________________________________________________________________

**If you miss your appointment, or fail to give 24 hour cancellation notice you will be charged $45**

**Client Waiver Form:**

I have read the above information and have filled this form out to the best of my knowledge, and stated all of my medical conditions and injuries. I understand that the services offered today are not a substitute for medical care. I agree to inform Anju (Angela) Prasad of any changes in my health and medical condition. I understand that there shall be no liability on Anju (Angela) Prasad part should I forget to do so. All patient information, including, but not limited to, personal and medical information, is confidential and privileged. I have legal and ethical responsibility to maintain the privacy and confidentiality of patient health care information and to protect the privacy of patients.

**Disclaimer:**
Please contact a health care practitioner for assessing any health risks. Do not use if you are pregnant or nursing. These statements and the formulations given or listed to you from Anju (Angela) Prasad and Anju's Herbals Inc. Are not intended to diagnose, prescribe for, treat, or claim to prevent, mitigate, or

cure any human disease. They are intended for nutritional support only. Any information provided is for general informational purposes.

Client Name: ________________________________________________

Client Signature: _____________________________________________

Date: ______________________________________________________

**Appointment Time you would like to book:**

____________________________________________________________________________

**Payment Information:**

Upon filling out this intake form and booking an appointment, there will be a one time application fee of $25.

Please fill out your credit card information below:

O Mastercard    O Visa

Card # ___________________________________

Name of cardholder: Last _________________   First ________________

Expiry: Month _____ Day _____ Year ______

3 Digit Code on the back of card _____

Postal Code associated with card ______ - ______

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**** Thank you for your information. You will get a call within 24 hours to confirm your appointment time. As well as get a receipt for your one time intake application form fee.**