Anju's Herbals
Anju Prasad - Ayurvedic Doctor
Private Practice – Victoria, BC
250.893.6948 – anjusherbals.com

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 my services? _____

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 what concerns you **today, or did in the past**:

O Asthma
O Diabetes
O Arthritis
O Constipation
O Diarrhea
O Allergies
O High Cholesterol
O Anxiety/Depression
O Headaches
O Heartburn
O Cancer
O Other _____

Past Childhood Illnesses

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

Vaccinations

O DPT (Diphtheria Pertussis, Tetanus)
O MMR (Measles, Mumps, Rubella)
O Gardasil/Cervarix (HPV Vaccine)
O Haemophilus Influenza B
O Varivax/Varilrix (Chicken Pox)
O BCG (Tuberculosis)
O Hepatitis A
O Hepatitis B
O Flu/Influenza Vaccine

O Polio Vaccine
O Pneumococcal Conjugate (Meningitis/Pneumonia)
O Meningococcal C Conjugate (Meningitis)
O Covid Vaccine
O Other _____

Any reactions to the vaccines, please explain?

_____
_____
_____

Current Medications, Pharmaceuticals

_____
_____
_____
_____
_____

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?_____

5.) Medication _____ For _____ Start Date _____
Duration of time on drug _____ Reactions to drug?_____

6.) 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
O Injections
O 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/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 power lines 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:

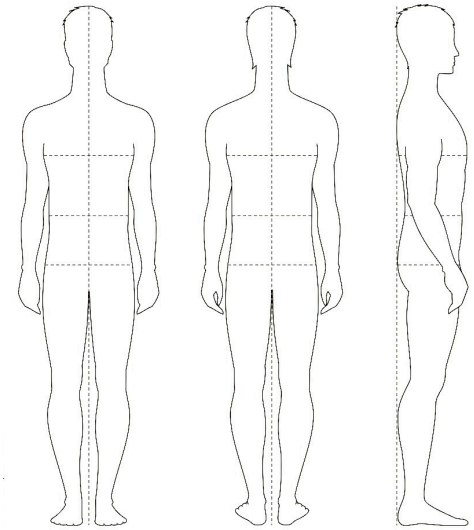
_____
_____

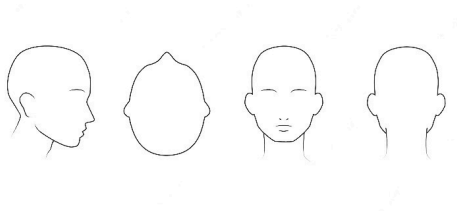
OTHER – Health Concerns & Additional Information

_____
_____
_____
_____

Please indicate in the diagram below, any areas of joint, muscle, bone pain, inflammation, broken bones/fractures, swelling, redness, accident/sports injuries, tenderness, heat, numbness:

_____
_____
_____
_____
_____





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* 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 GP 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 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 Name _____ First Name _____
Expiry: _____
Month _____ Day _____ Year _____
3 Digit Code on the back of card _____
Postal Code associated with card _____ - _____

* Thank you for your information. You will get an email within 24 hours to confirm your appointment time. As well as, get a receipt for your one time intake application form fee, or it will be added to your initial consult fee.