



Anju's Herbals
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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 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**:

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

Past Childhood Illnesses

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

Vaccinations

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

- ☐ Polio Vaccine
- ☐ Pneumococcal Conjugate (Meningitis/Pneumonia)
- ☐ Meningococcal C Conjugate (Meningitis)
- ☐ Covid Vaccine
- ☐ 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?

- ☐ Aspirin
- ☐ Laxatives
- ☐ Antacids
- ☐ Diet Pills
- ☐ Birth Control
- ☐ Injections
- ☐ Implants
- ☐ Recreational drugs – what and how often?

- ☐ Alcohol, how many drinks per day/ week? _____
- ☐ Tobacco _____ Amount/day? _____ How long? _____ Type? _____
- ☐ 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

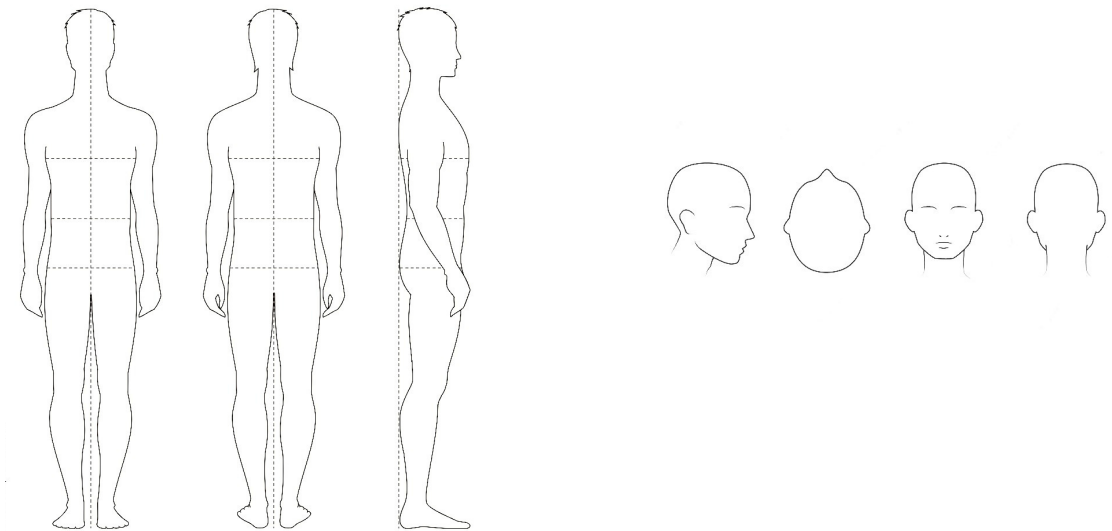
If yes:

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:



* 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

☐ Mastercard ☐ 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.
