Bloom Institute
OF HOLISTIC LIVING AND LEARNING

New Client Intake Form

PERSONAL INFORMATION

Name

Date of Birth | Age | Preferred Pronouns

Address | Suite

City | Postal code

Phone (day) | (evening)

Email

Occupation

Marital status

Children (#/ages)

How did you hear about this clinic?

MEDICAL INFORMATION

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so. Please complete the questionnaire as thoroughly as possible. Thank you.

What are the major health concerns that have brought you to this office today?

When did this begin?

Has anything recently changed or become worse?

Are you currently receiving health care from any other health professional? (Name)

For what condition?

Are you currently taking any medications, supplements or other remedies? ☐ YES ☐ NO

If yes, please list them:

Do you have any infectious diseases that you know of?

If yes, please list them:

Are you pregnant? ☐ YES ☐ NO If yes, how many months?

Do you have any known allergies or sensitivities? ☐ YES ☐ NO

If yes, please list them:

Is there any reason why you couldn't take remedies made in alcohol? ☐ YES ☐ NO

If yes, please specify:

Have you had any operations or been hospitalized? Please give date and reason.

FAMILY MEDICAL HISTORY

Please complete this section only for family members with particular health problems.

	Age	Health Problems	If deceased, age and cause
Father			
Mother			
Siblings			
Children			
Other			

PERSONAL HEALTH DETAILS

Height	Current weight	Weight 1 year ago	
Do you smoke?	How many years?	Amount per day?	
Do you drink alcohol?	What kind?	Frequency?	
Do you use recreational drugs?	What kind?	Frequency?	
Do you drink coffee?	How much?	Tea?	How much?
Do you exercise?	Frequency?		
Type?			
Duration?			

HEALTH CONCERNS

Please check off if you have experienced any of the following in the last three months.

Head, Eyes, Ears, Nose & Throat

☐ Poor vision	☐ Cataracts	☐ Glaucoma
☐ Earaches	☐ Blurred vision	☐ Poor hearing
☐ Ringing in ears	☐ Sore throat	☐ Canker sores
☐ Cold sores	☐ Grinding teeth	☐ Nose bleed
☐ Facial pain	☐ Clicking jaw	☐ Eye pain
☐ Sinus congestion	☐ Mucous in throat	☐ Swollen glands
☐ Ear infections	☐ Dizziness	☐ Frequent colds
☐ Spots in front of eyes	☐ Other _____	

Skin & Hair

☐ Rashes ☐ Poorly healing sores ☐ Hives
☐ Itching ☐ Eczema ☐ Psoriasis
☐ Pimples ☐ Dandruff ☐ Hair loss
☐ Recent moles ☐ Change in skin texture
☐ Other _____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain
☐ Irregular heart beat ☐ Fainting ☐ Cold hands or feet
☐ Other _____

Respiratory

☐ Cough ☐ Bronchitis ☐ Asthma
☐ Coughing blood ☐ Pneumonia ☐ Pain with breathing
☐ Shortness of breath ☐ Production of phlegm. If yes, what colour? _____
☐ Other _____

Gastro-Intestinal

☐ Nausea ☐ Vomiting ☐ Diarrhoea
☐ Constipation ☐ Black stools ☐ Pale stools
☐ Bad breath ☐ Abdominal pain ☐ Indigestion
☐ Heartburn ☐ Blood in stools ☐ Mucous in stools
☐ Rectal pain ☐ Haemorrhoids ☐ Gas
☐ Bloating ☐ Food cravings ☐ Poor appetite
☐ Difficulty swallowing # of bowel movements per day _____
Bowel movements: ☐ Loose ☐ Normal ☐ Hard
Other: _____

Urinary

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine
☐ Urgency to urinate ☐ Kidney stones ☐ Irregular flow
☐ Impotency ☐ Inability to hold urine ☐ Decrease in flow
☐ Difficulty starting or stopping flow ☐ Urinary tract infections
☐ Other _____

Musculoskeletal

☐ Neck pain ☐ Muscle pain ☐ Stiffness

☐ Back pain ☐ Muscle weakness ☐ Reduced range of movement

Do you see a Chiropractor or massage therapist? _____

☐ Other _____

Female Reproductive

_____ Age at first period _____ Age at menopause _____ Length of cycle

_____ Duration of bleeding ☐ PMS If yes, describe _____

☐ Heavy bleeding ☐ Discharges ☐ Clots

☐ Breast lumps ☐ Severe menstrual cramps ☐ Pain with intercourse

☐ Bleeding between periods

Date and result of last Pap test _____

_____ # of pregnancies _____ # of births _____ Miscarriages

_____ Premature births _____ Abortions

Type(s) of birth control used _____

Do you practice breast self examination? ☐ YES ☐ NO

Male Reproductive

☐ Prostate enlargement ☐ Erectile disfunctoin ☐ Changes in urine flow (see Urinary)

☐ Jock itch ☐ Other _____

Neuro/psychological

☐ Poor sleep ☐ Poor memory ☐ Numbness

☐ Depression ☐ Irritability ☐ Anxiety

☐ Seizures ☐ High stress levels ☐ Migraine

☐ Headaches ☐ Difficulty concentrating ☐ Foggy or spacey feeling

☐ Lack of coordination ☐ Lack of balance _____ Hours of sleep per 24 hours

☐ Other _____

General

☐ Fatigue ☐ Fevers ☐ Weight loss

☐ Night sweats ☐ Excessive thirst ☐ Chills

☐ Slow metablolism ☐ Intolerance to heat ☐ Intolerance to cold

☐ Sudden energy drops ☐ Weight gain

Do you remember your dreams? ☐ YES ☐ NO

Anything else you'd like to share?

_____

_____

_____

_____

_____

_____ Savayda Jarone, RHP Registered Herbal Practitioner
_____ Supervised student clinic
Other: _____

I, the undersigned, hereby confirm that I am consulting with the above named individual of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the therapist will offer an assessment of my general health and will make dietary and herbal recommendations.

If the consult is for a supervised student clinic I, the undersigned hereby confirm that I give consent for students of the Bloom Institute of Herbal Studies practitioner program to observe and participate in the consult and recommendation process.

_____ _____

Signature Date

The Bloom Institute operates a full herbal dispensary. Upon considering the herbal recommendations proposed by your practitioner, you have the option of purchasing a customized herbal remedy(s) at the end of the consultation.