

New Client Intake Form & Information Sheet

Welcome to Apothecary Tinctura!

We are a retail medicinal herb store specializing in natural remedies and health solutions for women. We have a small but busy 'clinic'/healing center/spa where we offer private consultation and treatments by skilled practitioners in a safe, nurturing environment. We specialize in women's health care integrating herbal medicine, aromatherapy, dietary counseling and Maya Uterine Massage into comprehensive holistic treatment plans.

Our mission is to provide an environment that allows healing to naturally happen...where all aspects of who we are and what our lives are about are welcome. Our goal is to provide you with the information and educational avenues needed to support self-healing and integration of herbal medicines, natural remedies and elements of self-care and beauty into your life. Whether you are here for a nurturing massage or have come seeking support for more serious health challenges, we welcome you.

How to Find Us

We are located on the corner of 6th Avenue & Fillmore St. just north of Cherry Creek
address: 2900 East 6th Ave, Denver 80206 tel: 303.399.1175

Cancellation / Re-Scheduling Policy

In order to best serve our clients and respect our clinic practitioners:

- We ask for a credit card number to reserve all clinic appointments
- We require at least 24 hours notice to cancel or reschedule an appointment
- We will not charge your credit card unless you miss your appointment or cancel/change your appointment with less than 24 hours notice
- A \$45 cancellation/rescheduling fee will be charged if less than 24 hours notice is given

I have read and understand the cancellation/re-scheduling policy

Client signature _____ date _____

Address _____

Email _____

Phone _____

We look forward to seeing you soon! Please bring your completed intake form with you to your first appointment.

Client Name:

Date:

DOB:

Age:

Gender:

List in Order of Importance Chief Concerns:

1) _____

2) _____

3) _____

4) _____

What are your health goals: -

Family History

	Father	Mother	Grandparents	Spouse	Children
Age (if Living):	_____	_____	_____	_____	_____
Age Deceased:	_____	_____	_____	_____	_____
Cause of Death:	_____	_____	_____	_____	_____
Cancer (list type):	_____	_____	_____	_____	_____
High Blood Pressure:	_____	_____	_____	_____	_____
Heart Attack/ Stroke:	_____	_____	_____	_____	_____
Asthma/Allergies:	_____	_____	_____	_____	_____
Mental Illness:	_____	_____	_____	_____	_____
Autoimmune dz:	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____
Osteoporosis:	_____	_____	_____	_____	_____

Addictions:

Alzheimer's/Dementia:

List All Surgeries and Hospitalizations, including dates:

1) _____ 2) _____
3) _____ 4) _____

Medications Used in Past (Please describe all medications that you can recall being prescribed, including the approximate dates and duration):

Please Note When and Why You Have Had Each of the Following:

X-Rays _____ **MRI/CTScan** _____

Ultrasounds: _____ **Accidents** _____

HIV _____ **HCV** _____

Last Eye Exam _____ **Last Dental Visit** _____

Please List Yes, No, or Past regarding use of the following:

Antacids: Y N P Steroids: Y N P Analgesics: Y N P

Cigarettes: Y N P Packs per day: _____ Number of Years: _____

Coffee: Y N P Cups per Day: _____ Soda: Y N P Cups per Day: _____

Alcohol: Y N P How much and how often: _____ Alcohol Addiction: Y N P

Alcohol Treatment: _____ Recreational Drugs: _____ Drug Treatment: _____

Please List All prescription Medicines, Supplements/Herbs that you are taking *including dosage:*

Diet

Please describe a typical day:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Dessert: _____

Beverages: _____

What types of foods do you crave?

If you could eat one thing every day without care over calories, what would that be? _____

What foods are you averse to? _____

Do you have any foods that make you feel ill when you eat them? _____

Do you crave sweets often? _____

When you do crave sweets, how do you satisfy the craving? _____

Do you like to cook? Y N

How often do you eat out? Twice per Day Once per Day Once or Twice a Week Never

Are you interested in learning how to cook healthy, delicious food? Y N

Review Of Systems

Present Weight:

Height:

Maximum Weight and When: Ideal Weight:

For the rest of the questions, Please circle Y (yes), N (no), or P (past)

Skin

Rash: Y N P

Color Change: Y N P

Hives: Y N P

Lump(s): Y N P

Psoriasis/Eczema: Y N P

Itchiness: Y N P

Dry: Y N P

Warts/moles: Y N P

Cancer: Y N P

Perspiration: Y N P

Head

Headache: Y N P

Migraine: Y N P

Dandruff: Y N P

Head Injury: Y N P

Oily/dry hair: Y N P

Hair loss: Y N P

Nose

Frequent Colds: Y N P

Nosebleeds: Y N P

Congestion: Y N P

Post Nasal Drip: Y N P

Polyps: Y N P

Seasonal Allergies: Y N P

Eyes

Dry/ Watery: Y N P

Blurry Vision: Y N P

Double Vision: Y N P

Catartacts: Y N P

Glaucoma: Y N P

Styes: Y N P

Strain: Y N P

Discharge: Y N P

Itchy: Y N P

Dark under eyes: Y N P

Mouth/Throat

Canker Sores: Y N P

Cold sores: Y N P

Sore throat: Y N P

Bleeding Gums: Y N P

Dentures: Y N P

Cavities: Y N P

Loss of Taste: Y N P

Hoarseness: Y N P

Neck

Stiffness: Y N P

Swollen Glands: Y N P

Restricted Movement: Y N P

Tension: Y N P

Respiratory

Cough: Y N P

TB: Y N P

Shortness of Breath: Y N P

Bronchitis: Y N P

Pneumonia: Y N P

Asthma: Y N P

Wheezing: Y N P

Painful Breathing: Y N P

Cardiovascular

High Blood Pressure: Y N P

Rheumatic Fever: Y N P

Low Blood Pressure: Y N P

Murmurs: Y N P

Arrhythmias: Y N P

Palpitations: Y N P

Edema: Y N P

Chest Pain: Y N P

Urinary Tract

Incontinence: Y N P

Pain w/ urination: Y N P

Frequent Infections: Y N P

Kidney Stones: Y N P

Urgency: Y N P

Discharge/ Blood: Y N P

Gastrointestinal

Heartburn: Y N P

Daily Bowel Movements: Y N P

Indigestion: Y N P

Recent Change in BM: Y N P

Bloating: Y N P

Diarrhea/Constipation: Y N P

Vomiting: Y N P

Hemorrhoids: Y N P

Change in Appetite: Y N P

Gall Bladder Disease: Y N P

Pancreatitis: Y N P

Liver Disease: Y N P

Ulcer: Y N P

Male Genitalia

Testicular Pain/Swelling: Y N P

Sexually Active: Y N P

Hernia: Y N P

STD: Y N P

Discharge: Y N P

Prostate Disease: Y N P

Difficulty with Urination: Y N P

Impotency: Y N P

Female Genitalia

Age Period Began:

How Often Period Occurs:

How Long Period Lasts:

Heavy Menstrual Bleeding:

Menstrual Cramping: Y N P

Menstrual Pain: Y N P

PMS: Y N P

Food Cravings: Y N P

Pregnancy: Y N P How many: _____

Miscarriages: Y N P

Last Pap Smear: _____

Abortions: Y N P

Abnormal Pap: Y N P

Menopausal: Y N Since What Age: _____

Menopausal Symptoms: _____

Use of Hormones: Y N P

Healthy Libido: Y N P

Vaginal Dryness: Y N P

Sexually Active: Y N P

Pain w/ Intercourse: Y N P

Vaginitis: Y N P

STD: Y N P If yes, please list: _____

Last Mammogram: _____ Ever an abnormal mammogram? _____

Any family or personal history of breast, uterine, or ovarian cancer? _____

Last Dexa Scan: _____ What were results? _____

Please list any birth control and ages used: _____

Musculoskeletal

Weakness: Y N P

Arthritis: : Y N P

Stiffness: : Y N P

Leg Cramps: : Y N P

Tremors: : Y N P

Pain: : Y N P

Nervous

Paralysis: : Y N P

Sciatica: : Y N P

Tingling/Numbness: : Y N P

Carpal Tunnel Syndrome: : Y N P

Seizures: : Y N P

Fainting: : Y N P

Mental/Emotional

Depression: : Y N P

Anger/irritability: : Y N P

Suicidal: : Y N P

High strung/tense: : Y N P

Anxiety: : Y N P

Fear/Panic: : Y N P

Eating disorder: : Y N P

Psych hospitalization: : Y N P

Do you have a strong community that you feel supports you? Y N

Are you close with your family? Y N

Any history of physical, emotional, or sexual abuse? Y N

Exercise

How often do you exercise:_____ For how many minutes?_____

What type of exercise do you prefer?_____

Do you feel like you are in good shape?_____

What are your hobbies and talents?_____

Sleep

How many hours do you sleep per night?_____

Do you fall asleep easily?_____

Do you wake during the night? Y N If so, how often?_____

Do you wake feeling refreshed? Y N Do you nap during the day?_____

Do you get sleepy in the afternoons?_____

Toxin Exposure

Have you ever had any toxic exposures that you are aware of? Y N

Have you ever lived near a refinery, a farm, or a polluted area? Y N

Did you grow up in a house built before 1976 that had leaded paint? Y N

Do you use solvents in any of your work or hobbies?_____

Have you ever experienced health problems after putting in new carpeting, new paint, or any other refurbishing in your home? Y N

Are you sensitive to medications? Do easily experience adverse effects?_____

Are you very sensitive to caffeine?_____

Are you sensitive to smells? Y N What happens?_____

Do you use pesticides, herbicides, or other chemicals in your home?_____

Do you have mercury fillings in your mouth? Y N How many? _____

Have you ever worked for the airline industry? Y N For how long? _____

What kind of career do you have? _____

Do you enjoy you job? _____

What are your hobbies? _____

Social Life

Are you in a relationship? Y N Are you happy with your relationship (or lack of)? Y N

Do you consider yourself to be a happy person? _____

How do you rate your levels of stress? High Moderate Little None _____

When you look back on your life, what was your happiest time? _____

How committed to your health are you? _____

What challenges do you expect to face in your process of moving to your ideal health? _____

Is there anything else that you would like me to know? _____

Thank you for your openness and thoroughness! All of this information helps me to get to know you as thoroughly as I can from the “get go” So that we can maximize out time together.

A few words about what you can expect from our work together: One of the things that I love about naturopathic medicine is that the doctor educates and guides the patient along their healing process, but YOU (the patient) are the main driving force in your healing process. In order to make real improvements in your health, YOU need to be pro-active and committed.

I am looking forward to working together!