

## 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 6<sup>th</sup> Avenue & Fillmore St. just north of Cherry Creek  
address: 2900 East 6<sup>th</sup> 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 \_\_\_\_\_

**scheduled date and time of first visit** \_\_\_\_\_

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

**Apothecary Tinctura**  
**Prenatal Massage Intake Form**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (evening) \_\_\_\_\_

E-mail: \_\_\_\_\_

How did you find us? Referred by: \_\_\_\_\_

What would you like help with at this time?

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Present physical complaints:

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Onset and length of symptoms:

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List any medications you are presently taking:

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List any herbal medicines, supplements, homeopathics, or over the counter medications you are presently taking:

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**PAST MEDICAL HISTORY**

Surgical history: \_\_\_\_\_

Other hospitalizations: \_\_\_\_\_

Serious accidents, falls or injuries: \_\_\_\_\_

Any childhood accidents or physical traumas? \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ To what? \_\_\_\_\_

## WOMEN'S HEALTH/ Pregnancy Information

Expected due date \_\_\_\_\_ # of weeks pregnant \_\_\_\_\_

Name of your Doctor or Midwife \_\_\_\_\_ Phone \_\_\_\_\_

Are you seeing a doctor/midwife regularly? YES or NO Date of last visit \_\_\_\_\_

Details of last visit \_\_\_\_\_

How has your pregnancy been progressing? (physically/emotionally) \_\_\_\_\_

Have you had any problems/complications or been at high risk in this pregnancy? Y or N

If yes, please explain-

Is this your first pregnancy? yes/no

If this is not your first pregnancy, how were your previous pregnancies and births?

How many pregnancies? \_\_\_\_ Number of deliveries: \_\_\_\_ Vaginal \_\_\_\_ C-Section \_\_\_\_

Any complications? \_\_\_\_\_

Any problems post-partum? \_\_\_\_\_

Have you had any miscarriages? \_\_\_\_ If so, when? \_\_\_\_\_

Have you had any abortions? \_\_\_\_ If so, when? \_\_\_\_\_

Please check any of the following conditions you are experiencing or have experienced:

<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heartburn/acid reflux	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Sore Heels
<input type="checkbox"/> Round ligament discomfort	<input type="checkbox"/> Spider/varicose veins	<input type="checkbox"/> Herpes outbreak
<input type="checkbox"/> Pubic symphysis separation	<input type="checkbox"/> Edema	<input type="checkbox"/> Antepartal bleeding
<input type="checkbox"/> Yeast/vaginal infection	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other
<input type="checkbox"/> Blood clotting disorder	<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Pre Eclampsia	
<input type="checkbox"/> DES exposure	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Placental dysfunction	<input type="checkbox"/> Problems with your cervix	

Have you ever been told you have a tipped or tilted uterus? \_\_\_\_\_

Have you had a prenatal massage before? Y or N Date of last prenatal massage \_\_\_\_\_

Anything your really liked about it? \_\_\_\_\_

or disliked about it? \_\_\_\_\_

## GENERAL

Do you have or have you had any of the following?

High blood pressure	____	Acne	____	Anorexia/Bulimia	____
Diabetes	____	Headaches	____	Heart problems	____
Hepatitis	____	Skin rashes	____	Kidney problems	____
Cancer	____	Skin fungus	____	Fainting spells	____
Frequent cold or flu	____	Sinus Problem	____	Emotional problems	____
Rheumatoid arthritis	____	Sceroderma	____	Lupus	____

**STRESS LEVEL**

What would you rate your level of stress ( 0= no stress, 10 = maximum stress) \_\_\_\_\_

What are the major sources of stress in your life? \_\_\_\_\_

Who provides you support in your life? \_\_\_\_\_

How many hours of sleep do you get on an average night? \_\_\_\_\_

Do you usually wake up feeling tired \_\_\_\_ or rested \_\_\_\_\_?

Nerves: good \_\_\_\_ fair \_\_\_\_ poor \_\_\_\_

Anxiousness: often \_\_\_\_ sometimes \_\_\_\_ seldom \_\_\_\_

Depression: often \_\_\_\_ sometimes \_\_\_\_ seldom \_\_\_\_

Please explain your responses: \_\_\_\_\_

\_\_\_\_\_

**WORK AND RECREATIONAL ACTIVITIES**

Occupation: \_\_\_\_\_

Do you enjoy your work? \_\_\_\_\_

Are you involved with activities outside of work? \_\_\_\_\_

If so, what type of activities? \_\_\_\_\_

Do you have any hobbies or interests? \_\_\_\_\_

Do you have a satisfying love life? \_\_\_\_\_

**BIRTH PREPARATION**

Are you taking a childbirth education class? If yes, which type of class and where?

\_\_\_\_\_

\_\_\_\_\_

Are you planning on taking a breastfeeding class BEFORE your baby is born? If yes, when and where?

\_\_\_\_\_

\_\_\_\_\_

Being totally honest, what are your greatest hopes and greatest fears related to...

**a.) Being pregnant**

Greatest hopes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Greatest fears: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**b.) Birthing your baby**

Greatest hopes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Greatest fears: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**c.) The post-partum period after birth and breastfeeding**

Greatest hopes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Greatest fears: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else related to pregnancy or birth that you would like information about at this time?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_