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 ________________

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.

INTAKE FORM
Herbal Consult and/or Maya Abdominal & Uterine Massage

Date:___________

Name: _______________________________________ Age:______ Sex: M F
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?
____
____
____

Present Physical Complaints: ____
____
____

Onset and Length of Symptoms: ____
____
____

At or Around the Time of Onset were there other Emotional Stresses Occurring?_______
____

List Any Medications you are Presently Taking:_______________________________
____

List Any Herbal Medicines, Supplements, Homeopathics, Over the Counter Medications you are Presently Taking:
____
____
____

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?______________________________

Present Weight: _____ One Year Ago: ______ 5 Years Ago: ______

WOMEN'S HEALTH

Do you experience any of the following, past or present? PLEASE CIRCLE

Breast pain	Fibroids	Hot flashes
Irregular PAP	Vaginal dryness	Difficult menopause
Difficulty getting pregnant	Ovarian cysts	Pelvic pain
Endometriosis	Vaginal infection	Currently pregnant
STD's including HPV	Irregular menstrual cycles	

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? _________________________________

Method of contraception: ____

Do you have an IUD ? ___________________________________

Do you have any pain with intercourse? _______________________________________

Do you have difficulty achieving orgasm? _____________________________________

Do you have any problems with incontinence (difficulty holding your urine)? _________

Date of Last Menstrual Period? __________________

MENSTRUAL PATTERN (check all that apply):

Symptom	Yes	No	Explanation
Painful Menstruation			
Clots			
Irregular Cycles			
Dark Blood at Onset			
Dark Blood at Conclusion			
Heaviness in Lower Pelvis			
Weak or Numb Legs			
Other:			

How many days do you bleed?

Light, medium or heavy flow?

Date of last pelvic exam?

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

MENOPAUSE:

Have you entered Menopause yet? _____ If so, at what age? _____

Please check below if you have experienced any of the following:

Hot Flashes	___	Memory Loss	___	Depression	___
Insomnia	___	Mood Swings	___	Fatigue	___

Do any of the women on your mother's side of the family suffer from any of the following:

Infertility ___ Menstrual Problems ___ Difficult Menopause ___

Are you now, or have you ever taken: Birth Control Pills____ Hormone Replacement Therapy? ___

GENERAL

Do You Have or Have You Had Any of the Following?

High Blood Pressure	___	Acne	___	Anorexia/Bulemia	___
Diabetes	___	Headaches	___	Heart Problems	___
Hepatitis	___	Skin Rashes	___	Kidney Problems	___
Cancer	___	Skin Fungus	___	Fainting Spells	___
Frequent Cold or Flu	___	Sinus Problem	___	Emotional Problems	___

FAMILY HISTORY (List any medical conditions, problems in family members)

LIFESTYLE

Tobacco Use: Yes No How Much and How Often: ___________________________

Alcohol Use: Yes No How Much and How Often: ___________________________

Caffeine Use: Yes No How Much and How Often: ___________________________

Other Drug Use: Yes No How Much and How Often: ___________________________

How Frequently Do You Exercise? Daily ___ Weekly ___ Rarely ___

Type of Exercise: ____

DIET

Breakfast: ____

Lunch: ____

Dinner: ____

How Many Meals Per Week Do You Order or Dine Out? _________

How Many Times Per Week Do You Have:

Beef	___	White Rice	___	Soda Pop	___
Pork	___	White Bread	___	Coffee	___
Fish	___	Crackers	___	Black Tea	___
Chicken	___	Chips	___	Milk	___
Canned Foods	___	Ice Cream	___	Other Dairy	___
Desserts	___				

How Many Glasses of Water Do You Drink Daily? _____

What Would You Say is the Worst Thing That You Do on Your Diet? _______________

____

Are You Subject to Binge Eating? _____ Of What Foods? _________________________

What Food Do You Find To Be Your Weakness? ________________________________

DIGESTION

Appetite: good fair poor Explanation: ___________________________________

Digestion: good fair poor Explanation: ___________________________________

Do you experience Bloating or Gas after meals? ____ Sour Burps or heartburn? _______

Do you feel Sleepy or Tired after meals? ______ How Often? Daily /Weekly /Occasional

Are you on a Restricted Diet? _________ Explain:_________________________________

ELIMINATION

How often do you have a bowel movement? Daily __ __Times per Week Irregular __

Do you ever have hard stools? ___ Do you ever have loose stools? ___

Urination: normal ___ scanty ___ more than 5 times daily ___burning ___ strong odor ___ dark color ___

Any history of bladder or kidney infections? _____ If so, at what age? ______________

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: ____
____

EMOTIONAL AND SPIRITUAL
If romantically involved, how is your relationship? ______________________________
____
Were there any emotional traumas in your early or present life? Please explain briefly.
(ie. rape, great loss, suicide or death of a loved one, etc.) _______________________
____
If possible, please explain what you feel to be your most experienced negative emotion:
____
When do you most often feel this emotion? ____________________________________
Where are you, when you feel this negative emotion? ____________________________
What is your opinion of yourself? ____
Have you ever been to counseling? ____ What was the outcome for you? ____________
____
Do you pray to a higher power? ___ How Often? ________
Do you meditate? _____ If so, how often? ________

Rate Yourself:	None	Some	Lots
Faith			
Hope			
Charity			
Generosity			
Humor			
Fun			

Is there an unrealized longing in your life? ___ What is it? _______________________
Briefly explain your relationship with each of your parents? ______________________
____

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? ____