Todd Caldecott, Cl.H., RH(AHG), RHT(BCHA), CAP(NAMA)
Clinical Herbalist, Ayurveda Practitioner

Clinic Intake Form and Health Profile

PART ONE: PERSONAL INFORMATION

Name: _____ Gender: _____
Date of birth: _____ Age: _____ Ancestry: _____
Address
Suite/Street: _____ City: _____ Postal Code: _____
Phone number (home): _____ (work): _____ (cell): _____
Email address: _____ Website: _____
Employment Status: ☐Full time ☐Part Time ☐Student ☐Retired ☐Unemployed ☐Other: _____
Occupation: _____ Marital Status: _____
Children (#/ages): _____ Medical doctor: _____

Please complete this questionnaire as thoroughly as possible.
Where did you hear about this clinic?

_____
What are the major health concerns that brought you here today?

_____
_____
_____
_____
When did this condition begin? _____

_____
Are you currently receiving care from any other health professional(s)? (Please provide names)

_____
_____
For which condition(s)? _____

_____
Do you have any recent bloodwork, imaging studies or screenings? ☐No ☐Yes, if so, please attach to this intake.

Are you currently using any supplements and/or medications? Please continue on a separate page if necessary.

Drugs/OTCs/Herbs/Supplements?	Brand	Prescriber	Strength	Dose	Frequency

Do you have any infectious diseases that you know of? ☐Yes ☐No
If yes please list: _____

_____
Is there any chance that you are pregnant? ☐Yes ☐No
Do you have any known allergies or sensitivities (drugs, pollen, dander, foods, latex etc)?

_____
_____
Is there any reason you cannot ingest herbal remedies prepared in food-grade alcohol?

_____

Have you ever undergone surgery or been hospitalized? (Please provide the date and reason)

Date	Surgery/hospitalization	Reason/diagnosis	Hospital/location	Complications/notes

Family Medical History

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

Relationship	Age	Living (✓)	Deceased (✓)	Health issue
Mother				
Father				
Sibling				
Sibling				
Children				
Children				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Other:				

Personal Health Habits

Height: ___ Current Weight: ____Weight 1 year ago: ____ Weight in your early 20's: ___ Waist/hip circumference:___/___
Are you a smoker? _____ Years? _____ #/day? _____ Have you smoked in the past? ____ When did you quit? _____
Do you use recreational drugs? _____ What types? _____ How often? _____times/week/month.
Do you exercise regularly? ____ Frequency? ____ times/week Type(s)? _____ Duration? _____

Diet

Do you drink alcohol? ☐Yes ☐ No If yes, what types? _____ How often? _____ times/week.
Do you drink coffee? ☐Yes ☐ No How often? _____ times/week. How much? ____ cups/day.
Do you drink black tea? ☐Yes ☐No How often? _____ times/week. How much? ____ cups/day.
Do you make a point to drink water daily? ☐ Yes ☐ No How often? _____ times/week. How much? ___glasses/day.

To the best of your ability, please indicate what you typically eat on a daily basis (please be honest):

Meal	When?	Description
Breakfast		
Lunch		
Supper		
Snacks		

Do you indulge in sweets and deserts? ☐Yes ☐No How often? _____times/week How much? _____ servings/day.

Do you now or have you ever followed a restricted diet? Please describe and indicate when:

Diet plan	When?	For how long?	Reason

PART TWO: HEALTH CONCERNS
Please check those issues you have experienced in the last 3 months.

Skin and Hair

- ☐ Rashes
- ☐ Poor healing sores
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Pimples
- ☐ Acne
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Recent changes in skin texture

Any other noted problems with your skin, nails or hair?

Head, Eyes, Ears, Nose and Throat

- ☐ Poor vision
- ☐ Floaters
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blurred vision
- ☐ Eye pain
- ☐ Earaches
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Sore throat
- ☐ Canker sores
- ☐ Oral herpes, if yes how often? _____times/year
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Clicking jaw
- ☐ Jaw pain
- ☐ Mucous in throat
- ☐ Nosebleeds
- ☐ Dizziness
- ☐ Frequent colds
- ☐ Swollen glands

Any other problems with your head, eyes, ears, nose or throat?

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest/heart pain
- ☐ Fainting
- ☐ Irregular heart beat
- ☐ Cold hands or feet
- ☐ Ankle swelling
- ☐ Palpitations
- ☐ Easy bruising
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Breathing difficulties

Any other problems with your heart or circulation?

Gastro-Intestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bad breath
- ☐ Excessive burping
- ☐ Poor appetite
- ☐ Food cravings (e.g. sweets)
- ☐ Indigestion
- ☐ Gas/bloating
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Ulcers
- ☐ Mucous in stools
- ☐ Blood in stools
- ☐ Black stools
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Gallstones
- ☐ Difficulty swallowing
- ☐ Crohn's/colitis
- ☐ Liver problems

How many bowel movements do you have a day? ☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4+
How would you describe your bowel movements? ☐ Loose ☐ Normal ☐ Hard ☐ Tarry
Do your stools: ☐ float? ☐ sink? ☐ have a bad odor? ☐ have no odor? ☐ display blood?
Do you rely on: ☐ Enemas ☐ Laxatives or ☐ Purgatives for bowel elimination? If yes, how often? _____times/week

Any other digestive problems?

Respiratory

- ☐ Chronic cold/flu
- ☐ Sinusitis
- ☐ Hayfever
- ☐ Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Pain on breathing
- ☐ Shortness of breath *with* exertion
- ☐ Shortness of breath *without* exertion
- ☐ Difficulty breathing when lying down
- ☐ Production of phlegm, if yes what color?_____

Any other problems with breathing?

_____

Genito-urinary

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urgency of urination
- ☐ Inability to hold urine
- ☐ Decrease in flow
- ☐ Irregular flow
- ☐ Burning urine
- ☐ Difficulty stopping or starting
- ☐ Blood in urine
- ☐ Water retention
- ☐ Bladder/kidney infection
- ☐ Kidney/bladder stones
- ☐ Interstitial cystitis
- ☐ Prostate enlargement
- ☐ Erectile dysfunction
- ☐ STDs: _____

Any other problems with urination?

_____

Musculoskeletal

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ General joint pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Stiffness
- ☐ Reduced range of movement
- ☐ Muscle cramps or spasms
- ☐ Swelling in joints
- ☐ Bone pain
- ☐ History of fractures or broken bones
- ☐ Sprains or strains

Do you see an Osteopath, Chiropractor, Massage Therapist, and/or Movement specialist? (Please provide names/contact).

_____

_____

_____

Any other musculoskeletal problems?

_____

Female reproductive

- ☐ Discharge, if yes what is the color? _____
- ☐ Vaginal infection
- ☐ Vaginal itching
- ☐ Genital herpes
- ☐ Cervical dysplasia
- ☐ Endometriosis
- ☐ Uterine fibroids
- ☐ Uterine cysts
- ☐ Ovarian cysts
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Pelvic inflammatory disease
- ☐ Infertility
- ☐ Pain with intercourse (dyspareunia)
- ☐ Post-menopausal bleeding
- ☐ Anemia related to heavy periods
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Mastectomy
- ☐ Lumpectomy

Do you menstruate? ☐ Yes ☐ No
If yes, what is the length of your cycle (period to period):_____days, and the duration of bleeding _____days?
Would you characterize your flow as: ☐ Heavy ☐ Normal ☐ Light? Is the blood: ☐ Dark ☐ Normal ☐ Light?
Do you experience PMS? ☐ Yes ☐ No If yes, symptoms begin _____ days before period.

Female reproductive (continued)…

If you have PMS, which symptoms apply to you?

☐Anxiety
☐Irritability
☐Mood swings
☐Depression
☐Grief/sadness
☐Poor memory
☐Brain fog/confusion
☐Insomnia
☐Fatigue
☐Dizziness
☐Headaches
☐Breast tenderness
☐Bloating
☐Weight gain
☐Water retention
☐Increased appetite
☐Craving for sweets
☐Acne/skin eruptions
☐Palpitations
☐Lower back pain
☐Abdominal pain
☐Joint pain

Do you have breast implants? ☐Yes ☐No If yes, are they: ☐Silicon ☐Saline ☐Other
If yes, have you noted any problem with them? ☐Yes ☐No
Date and result of last PAP smear: _____
How many: pregnancies have you had? _____; births? _____ ; miscarriages?_____; premature births?____; abortions? _____

Do you or have you recently used contraceptives? ☐Yes ☐No
If yes, which ones?
☐IUD ☐Condoms ☐Diaphragm ☐Rhythm ☐Mucous method ☐Spermicidal jelly
☐Other (please describe): _____

Are you post-menopausal? ☐Yes ☐No
If yes, when was the approximate date of your last period? _____
If you have menopausal symptoms, please describe your major symptoms:
_____
_____

Do you have any other gynecological issues?
_____

Neuropsychological
☐Poor sleep
☐Anxiety
☐Irritability
☐Depression
☐Poor concentration
☐Poor memory
☐Headaches
☐Migraines
☐High stress levels
☐Loss of balance/coordination
☐Numbness, if yes, where? _____
☐Vertigo
☐Seizures
☐Muscle spasm/twitching

How many hours do you sleep each night? _____ Do you feel constantly tired upon wakening? _____
Do you have any other neurological problems?
_____

Metabolic
☐Chronic fatigue
☐Fevers
☐Chills
☐Night sweats
☐Excessive thirst
☐Slow metabolism
☐Sudden energy drops
☐Intolerance to heat or cold
☐Recent weight gain
☐Recent weight loss

Any other health concerns or problems?
_____
Have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins encountered beyond what might be expected in one's day to day life?
_____

Mind and emotions
How do you feel about the following areas of your life? Please check appropriate boxes and make any comments you would like to

Parameter	Excellent	Good	Fair	Poor	Comments?
Self	☐	☐	☐	☐	
Spouse/Partner	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	
Family	☐	☐	☐	☐	
Life purpose	☐	☐	☐	☐	
Finances	☐	☐	☐	☐	

Are you able to express your feelings and emotions easily? ☐Yes ☐No
Is there an excess of stress in your life? ☐Yes ☐No If yes, what is causing you so much stress?
_____
_____

Do you have tools or techniques to relieve stress?☐Yes ☐No
Are you satisfied with your current living/working environment?☐Yes ☐No
If there is one thing in your life that you would like to change right now, what is it?
_____
_____

Are you a 'nervous type' person? ☐Yes ☐No If yes, what things make you most nervous?
_____
_____

What feelings do you most often experience in your life?
☐joy ☐happiness ☐anger ☐sadness ☐fear ☐anxiety ☐sympathy ☐worry ☐depression

Vision Statement
What are your desired goals for your visit to this clinic?
1. _____
2. _____
3. _____

Waiver of Liability
I, the undersigned, hereby confirm that I am consulting with Todd Caldecott of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that Todd Caldecott will offer an assessment of my general health and will make nutritional, herbal, supplemental, and lifestyle recommendations to support my health. I understand the importance of frequent monitoring to revise the treatment protocol as required.

Signature: _____ Date _____
Print name: _____

All case history notes and medical information recorded during the consultation are kept strictly confidential. Information contained herein will not be released to any person or agency except with your authorization or where required by law.