

**Wild Hill Herbal Clinic**  
**Susan Hoffman ~Herbalist**  
 296 Bobbin Shop Road, Chelsea, VT 05038  
 (802) 685-2038  
<http://www.wildhillherbals.com>

This is the form to fill out if you are booking a **Herbal & Whole Health Consultation**.  
 The intake forms for the **Herbal Mini** or the **Intuitive Reading** are on Pages 8 and 9.

We want to provide you with the best care possible and have created this form as a tool to learn more about your health situation. Please answer these questions as thoughtfully and as completely as possible. Some of the questions may seem unrelated or too personal but there is a purpose behind all of them. If you are uncomfortable answering anything feel free to omit it.

**If you are completing this form electronically** (the preferred method), please type your responses **INSIDE the SHADED text boxes**. If the version of Word you are using opens downloaded documents in 'protected' mode, you will need to 'enable editing' so that you can type in the boxes.

Don't let the box size limit you! You can type as much or as little as you like. The more you type the bigger the box will 'grow' to accommodate your words.

**If this is a printed form** and you are completing it by hand, please feel free to use extra paper for your responses, making it clear which question you are answering.

Thank you for taking the time to pursue your health and wellness.

<b>Name:</b>	<b>Today's Date:</b>	
<b>Date of Birth:</b>	<b>Age</b>	<b>Gender identity</b>
<b>Address:</b>	<b>Occupation:</b>	
<b>Phone #s</b>		
<b>Home:</b>	<b>Work:</b>	<b>Cell:</b>
<b>Best time to call:</b>	<b>Email:</b>	
<b>Who do you share your home with? :</b>		
<b>Do you have children?</b>	<b>If yes, age(s)</b>	<b>Pets? / Animals?</b>

- **What brought you here today? What is your main complaint? Please also list any secondary concerns you may have.**

**When did it begin? (Please answer fully)**

>>

- **What was happening in your life at that time? Please feel free to add whatever seems relevant to you here.**

- **What would you like to accomplish in our work together?**

- **What, if anything, is your opinion about your illness? What underlying issues may be involved? What do you think needs to happen for healing to take place around this condition/ issue? (Please answer fully)**

- **Date of last physical exam . What were the results?**

**If you can, please bring a copy of any medical test(s) you have had in the past couple of years to the consultation. Emailing them ahead of time would be helpful, if you are able to do this.**

- **Please comment on any or all of the following activities as they pertain to your life:**

Do you exercise regularly?(describe)	
Do you have a regular relaxation program and/or a spiritual practice? (describe)	
How would you describe your current energy level?	
How would you describe your stress level? What kinds of stressors are in your life?	
Do you have any specific interests or hobbies? If so, how much time (per week) do you take time for these?	
How many hours do you sleep each night?	
Do you dream?	
How would you describe your sleep?	
Do you wake during the night: if so, why and how frequently? Do you usually awake at a consistent time? if yes, What is that time?	
What is your occupation?	
Do you like your work? If no why not? (Please answer fully)	
Do you feel like you are using your gifts and talents in your work or in your life?	
<b>Do you use any of the following??</b>	
<b>Tobacco</b> (Cigarettes/cigars/chewing tobacco): How much/many per day?	
<b>Alcohol:</b> What kind? How many per day?	
<b>Recreational drugs:</b> What kind? How frequently?	
<b>Sugar</b> what kind? when and how much/day	
<b>Caffeine</b> what kind? When and how much /day?	

- **Name the two most dominant emotions in your life at this time:** [For example, Joy, Anger, Fear, Grief, Happiness, Sympathy, Anxiety, Sadness, Agitation, Peace, Other.

--

- **The following questions will help us design the best health program for you:**

What is your height and weight? Are you happy with this?	
Is your body most often warm or cold?	
Do you tend more toward dryness or dampness? For example, dry/oily hair or skin.	
How would you describe your energy as you pass through daily activities? Erratic or even? Frantic or calm?	
Do you lose energy and become tired at any time during the day?	
Do you feel better from movement or resting?	
When do you feel the best, in the morning when you wake, when you are ending your day, or somewhere in between?	
What kind of exercise would be ideal for you?	
What kind of weather/ climate do you enjoy the most? Are you living in that climate?	
Are you quick to anger? Are you able to express it or not? If so, how do you express it?	
Does your living situation suit you?	
How are your primary relationships?	
How do you deal with strong emotions, such as anger or sadness?	
WOMEN are you pre or post menopausal ? What is your female health history? Are you currently having any menopausal or midlife issues? Physical? emotional?	
MEN are you testapausal? Are you having any midlife issues? Physical? Emotional?	

- **List any other information you think we need to know about you, such as major life crisis you may be experiencing; financial stresses, relationship difficulties etc. (Please answer fully)**

--

## **FAMILY HEALTH HISTORY**

- **Have you or anyone in your family, ever suffered from any of the following health issues? Please state person concerned (self or relationship of person to you. and elaborate as needed)**

High or Low Blood Pressure	
Arthritis	
Depression	
Mental Illness	
Asthma	
Liver Disease	
Ulcers	
Acid reflux	
Kidney/ Bladder Problems	

Thyroid Imbalance	
Cancer	
Emphysema	
T.B.	
Auto-Immune Disorders	
Menstrual/Pregnancy Difficulties	
Dementia/Alzheimer's	
Blood sugar issues including Diabetes	
Musculoskeletal problems	
Osteoporosis or osteopenia	
Heart disease	

### SYMPTOMS CHECKLIST

- **Have you had any of these symptoms or diseases in the past or present?**

Please type your comments in the relevant box. Include dates to indicate when they occurred. If unsure put a question mark and we will discuss further.

Allergies	Accident	Headaches	Arthritis
Menstrual Pain	Incontinence	Painful Urination	Bloating
Memory loss	Eye Irritation	Hearing problems	Asthma
Too hot	Too cold	Chemical Sensitivities	Rashes
Hyperglycemia	Hypoglycemia	Alcoholism	Fatigue
Sleep Problems	Drug Abuse	High Blood Pressure	Low Blood pressure
Diabetes	Night Sweats	Teeth Grinding	Numbness
Diarrhea	Seizures	Fainting	Anemia
Constipation	Shingles	Swollen glands	Neck Pain
Eczema	Earache	Congestion	Nausea
Cancer	Tumors/Cysts	Earaches	Gas
Heartburn	Bad Dreams	Poor concentration	Phobias
Bruise Easily	Indigestion	Loneliness	Mania
Anger Outbursts	Back Pain	STD	Swelling
Sinus Infections	Painful joints		
Have you been vaccinated? If so for what?			

Have you ever had any severe injuries? What and when did this happen?	
Have you ever had major surgery? What and when did this happen?	
Have you ever been hospitalized? When? and what for?	

### FOOD FREQUENCY CHECKLIST

- **Please estimate how many servings of the following foods you eat in one week.** Note if you are eating organic

Red Meat		Fish	
Poultry		Fruit	
Beans/Legumes		Cheese	
Milk/Yogurt		Butter	
Soy products		Oils	
Chocolate		Coffee	
Green Veggies		Tea caffeinated? green?	
Potatoes sweet potatoes		Alcohol	
Yellow/red/orange Veggies		Soda	
Wheat Products		Herbal Tea	
Whole Grains		Pastries/Sweets	
Veggie Proteins		Chocolate	

<b>What condiments do you use?</b>	
Black pepper	
Ginger	
Spices	
Vinegar	
Cayenne/ Hot sauce	
Salt (what kind)	
Other	
What fats do you use: Butter, Margarine, Mayo, Oils (which oils)?	
What food or foods do you eat every day and/or could not imagine giving up?	

<b>On a monthly basis:</b>	
How frequently do you dine out at a restaurant?	
How often do you eat commercially produced 'fast foods'?	

- **Describe your diet in general, what does a typical day of eating look like for you? include the time of day that you eat**

- **What foods are most attractive to you? (Please answer fully)**

- **What foods do not agree with you? What happens when you eat them?**

- **Do you have any food allergies or sensitivities that you know of or suspect?**

- **If you could change anything about your eating habits, what would it be?**

<b>Do you have food cravings? What kinds of foods do you crave</b>	
<b>How much water do you drink a day? What kind of water is it?</b>	

- **Please list any vitamins or supplements you currently take (with dosage)**

- **Please list any herbal therapies you take (with dosage)**

- **Please list any prescription medications you are taking**

**NOTE: If you take any supplements or prescription medications on a daily basis, please bring them with you to the consultation**

Describe what you know about your birth	
Did your mother receive drugs during her pregnancy?	
During the birth?	
Any birth complications?	
Were you a forceps delivery/ Caesarean Section?	
Were you breast-fed? How long?	

- please list any traumas you may have experienced at any time of your life up till the present, include things like: death or loss of a family member or loved one, emotional or sexual abuse, a difficult divorce, long standing illness (yourself or someone close to you) caring for someone who is ill for an extended period, etc.

1. Is there ANYTHING we may have missed in this (apologetically), very extensive questionnaire that you feel it would be useful for us to know about you