DrHerbs intake form and appointment application

To help your practitioner get the correct info and reduce your conference time, please read and fill in carefully the form as below. Please forward your filled form via email: info@drherbs.ca

Section 1

First name: _____ Last name: _____ Sex:
Age: _____

Address:
Contact:
Family doctor contact:

List your current healthcare providers (includes medical doctors, chiropractors, counsellors, massage therapist, physiotherapist, acupuncturist).

_____

Do you have any known contagious diseases at this time?

- No
- Yes

IF YOU ANSWERED YES TO THE PREVIOUS QUESTION, WHAT?

_____

Email Correspondence (your email will never be sold, shared, or traded).

_____

I herby consent to have consultation from DrHerbs. I understand this consent is voluntary and may be revoked at any time. I accept responsibility for prompt payment for therapies provided.

- Yes
- No

FAMILY HISTORY RELATED WITH YOUR CONCERNS

- I do not know my family history (please skip to the next section, childhood illnesses).

Did you have any childhood illnesses? (Check all that apply)

- Chicken Pox
- Diphtheria
- Mumps
- Measles
- Scarlet Fever
- Asthma
- Rubella
- Whooping Cough
- Others

  _____

List known allergies or sensitivities:
Foods:
Medications:
Environmental factors:
Chemicals:

DO YOU CURRENTLY TAKE OR USE:

- Laxatives
- Pain Relievers

- Antacids
- Cortisone
- Sleeping Pills
- Antibiotics
- Anti-Depressants
- Hormones
- Birth Control Pills/Patch/Shot

LIST ALL CURRENT MEDICATIONS WITH DOSAGES:

Prescription medications:
Other the counter medications:
Supplements:
Natural Remedies (Herbal, Homeopathic):

WHAT ACCIDENTS/TRAUMAS HAVE YOU HAD?

WHAT HOSPITALIZATIONS OR SURGERIES HAVE YOU HAD?

WHAT MEDICAL TESTS (X-RAYS, CT SCANS, MRI, ECG) HAVE YOU HAD?

GENERAL INFORMATION -CURRENT HEIGHT?

GENERAL INFORMATION -CURRENT WEIGHT?

GENERAL INFORMATION -WHAT TIME OF DAY IS YOUR ENERGY THE BEST?

GENERAL INFORMATION -WHAT TIME OF DAY IS YOUR ENERGY THE WORST?

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) GENERAL:

- Weight Loss
- Weight Gain
- Fatigue
- Sleep Disturbance
- Tension
- Poor Circulation
- Memory Problems

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) IMMUNE:

- Reactions To Vaccinations
- Chronic Fatigue Syndrome
- Chronic Infections
- Chronically Swollen Glands
- Slow Wound Healing

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) ENDOCRINE:

- Thyroid Problems
- Heat Or Cold Intolerance
- Hypoglycaemia
- Diabetes
- Excessive Thirst
- Excessive Hunger
- Fatigue
- Seasonal Depression

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) NEUROLOGIC:

- Seizures/Epilepsy
- Paralysis
- Muscle Weakness
- Numbness Or Tingling
- Loss Of Memory
- Easily Stressed
- Vertigo Or Dizziness
- Loss Of Balance

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) MENTAL/EMOTIONAL:

- Depression
- Mood Swings
- Anxiety Or Nervousness
- Considered/Attempted Suicide

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) SKIN:

- Rashes
- Eczema Or Hives
- Acne
- Boils
- Itching
- Colour Change
- Hair Loss
- Lumps
- Dry Or Scaling
- Night Sweats
- Excessive Or No Sweat

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) MOUTH AND THROAT:

- Frequent Sore Throat
- Copious Saliva
- Teeth Grinding
- Mouth Ulcers
- Sore Tongue/Lips
- Gum Problems
- Hoarseness
- Loss Of Voice
- Dental Cavities
- Jaw Clicks
- Cold Sores

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) HEAD:

- Headaches
- Head Injury
- Migraines
- Jaw/ TMJ Problems
- Fainting

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) NECK:

- Lumps
- Swollen Glands
- Goiter
- Pain Or Stiffness

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) EARS:

- Hearing Loss
- Ringing
- Earaches
- Dizziness
- Sensitivity To Noise
- Discharge From Ears

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) CARDIOVASCULAR:

- Heart Disease
- High/Low Blood Pressure
- Murmurs
- Blood Clots
- Fainting

- Phlebitis
- Palpitations/Fluttering
- Rheumatic Fever
- Chest Pains
- Swelling In Ankles

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) RESPIRATORY:

- Cough
- Sputum (Mucus)
- Spitting Up Blood
- Wheezing
- Painful Breathing
- Emphysema
- Difficulty Breathing
- Pain On Breathing
- Shortness Of Breath
- Shortness Of Breath Laying Down

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) EYES:

- Glasses Or Contacts
- Colour Blind
- Double Vision
- Spots In Eyes
- Recent Change In Vision
- Blurred Vision
- Eye Pain/Strain
- Sensitive To Light
- Eyes Water Excessively
- Bloodshot Or Puffy Eyes
- Dryness

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) GASTROINTESTINAL:

- Frequent Bowel Movements
- Constipation
- Diarrhea
- Trouble Swallowing
- Heartburn

- Change In Thirst
- Change In Appetite
- Abdominal Pain Or Cramps
- Belching Or Passing Gas
- Nausea/Vomiting
- Hemorrhoids
- Black Stools
- Blood Or Mucus Stool
- Undigested Food In Stool
- Ulcer
- Jaundice (Yellow Skin)

HOW OFTEN ARE YOUR BOWEL MOVEMENTS AND IS THIS A CHANGE FOR YOU?

_____

Review of Systems (Check all continuing or recurrent problems)
Urinary:

- Pain On Urination
- Increased Frequency
- Frequent At Night
- Inability To Hold Urine

- Blood In Urine
- Difficulty Starting To Urinate
- Frequent Infections
- Kidney Stones

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) MUSCULOSKELETAL:

- Joint Pain Or Stiffness
- Broken Bones
- Muscle Weakness
- Muscle Spasms Or Cramps
- Sciatica

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) BLOOD/ PERIPHERAL VASCULAR:

- Easy Bleeding Or Bruising
- Anemia
- Deep Leg Pain
- Cold Hands/ Feet
- Varicose Veins
- Thrombophlebitis
- Fluid Retention

PLEASE ELABORATE ON AREAS WITHIN YOUR BODY THAT YOU CURRENTLY FEEL PAIN.

_____

Review of Systems (Check all continuing or recurrent problems)
Male Reproduction:

- Hernias
- Testicular Masses
- Testicular Pain
- Prostate Problems
- Venereal Disease
- Discharge Or Sores
- Erectile Dysfunction
- Low Libido
- Premature Ejaculation
- Sexually Transmitted Injection

MALES: DO YOU DO TESTICULAR SELF-EXAMS? ARE YOU SEXUALLY ACTIVE? ARE YOU ON BIRTH CONTROL? (PLEASE SPECIFY TYPE)

REVIEW OF SYSTEMS (CHECK ALL CONTINUING OR RECURRENT PROBLEMS) FEMALE REPRODUCTION:

- Recent Changes In Breasts
- Breast Lumps

- Breast Pain/Tenderness
- Nipple Discharge
- Low Libido
- Pain During Intercourse
- Sexually Transmitted Infection

FEMALES: DO YOU DO BREAST SELF-EXAMS? DATE OF YOUR LAST ANNUAL EXAM/PAP? HAVE YOU HAD ANY ABNORMAL PAPS? AGE OF FIRST MENSES? ARE YOU SEXUALLY ACTIVE?

PRE- MENOPAUSAL FEMALES:

- Irregular Cycle
- No Cycle
- Bleeding Between Cycles
- Abnormal Bleeding
- Painful Menses
- Clotting
- Heavy Or Excessive Flow
- Discharge
- PMS

- Birth Control

- Difficulty Conceiving
-
- Perimenopausal

WHAT IS THE DURATION OF YOUR MENSES? WHAT IS THE LENGTH OF YOUR CYCLE? IF YOU ANSWERED YES TO BIRTH CONTROL, WHICH TYPE ARE YOU ON?

MENOPAUSAL FEMALES: WHAT AGE WAS YOUR LAST MENSES? DO YOU HAVE ANY MENOPAUSAL SYMPTOMS? ANY VAGINAL BLEEDING SINCE MENOPAUSE?

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD OR COMMENT ON?

SECTION 2: HISTORY AND HEALTH INFORMATION.

DO YOU SMOKE?
- No

DO YOU DRINK ALCOHOL?
- No

PLEASE PROVIDE YOUR FAMILY PHYSICIAN'S NAME AND CONTACT INFORMATION.

DO YOU HAVE ANY ALLERGIES?
- No

IF YES, PLEASE LIST:

ARE YOU TAKING ANY MEDICATIONS/SUPPLEMENTS?
- No

IF YES, PLEASE LIST:

IF YOU ARE FEMALE, ARE YOU PREGNANT?
IF YES, WHEN IS YOUR EXPECTED DELIVERY DATE?

Please list the 3 main concerns that you would like to focus on, the first one is covered with your consultation:

A.
B.
C.

PLEASE INDICATE IN ANY OF THE FOLLOWING CONDITIONS APPLY TO YOU WITH A CHECK MARK:

- Heart Attack
- High/Low Blood Pressure
- Stroke/Aneurysm
- Pace Maker/Heart Condition
- Varicose Veins
- Bruise Easily
- Diabetes
- Kidney Disease
- Other Urinary Conditions
- Skin Condition

- Headache/Migraines
- Dizziness/Fainting
- Nausea
- Spinal Injury
- Epilepsy/Other Seizures
- Other Neurological Conditions
- Asthma
- Chronic Sinusitis
- Irritable Bowel/Colitis
- Digestive Issues
- Joint Dislocation
- Bone Fractures
- Arthritis
- Osteoporosis
- Rods/Pins/Plates/Shunts
- Transplant Surgery
- Cancer

- Hepatitis
- HIV/AIDS

IF YOU HAVE A CONDITION THAT WAS NOT LISTED PLEASE INDICATE:

_____

Please describe your current condition and symptoms:

HOW LONG HAVE YOU HAD THIS?

HOW DID IT START?

WHAT RELIEVES IT?

WHAT AGGRAVATES IT?

PLEASE INDICATE WHERE ON YOUR BODY YOU HAVE PAIN: (E.G.- LEFT OUTER SHOULDER)

I agree:

- The above information is correct to my knowledge and impacts on the correct diagnosis through virtual consultation.
- I am using virtual consultation and accept advice given for my concerns. Not to hold DrHerbs or any of its affiliates or practitioners responsible for any opinions given herein.
- A minimum of 24 HOURS notice is needed to change or cancel an appointment. You will be charged $15.00 for late cancellations or missed appointments.

Disclaimer:

The virtual consultation is a service provided by the DrHerbs office. The participants in the online consultation fully understand that the information provided by the practitioner is general information only and is not a substitute for an actual “in-person” consultation with the practitioner that is necessary prior to any major medical solution. Participants in this consultation agree not hold any parties liable to the opinions given herein.

Signature: _____ Date: _____

Preferred appointment time for video/voice chat conference (Pacific Time @ Vancouver, BC)

1 _____
2 _____