SUN & MOON
DISPENSARY
Plant Seeds of Health

Sheila M. Devitt, Herbalist

Client Intake Form

PATIENT INFORMATION
Date
Name
Address
City, State, Zip
Age
Birthdate (MM/DD/YYYY)
Gender
Height & Weight
Occupation
CONTACT INFORMATION
Phone Number
E-mail
Emergency Contact Name
E.C. Phone Number
E.C. Relationship
How did you hear about us?

HEALTH HISTORY
What is the primary reason for your visit today?
Secondary reason?
Do you have access to primary health care?
Name of Primary Health Care Provider:
Previous surgeries, hospitalizations?
Allergies to any medications, or other substances?
Please list any prescription medications you take:
Please list any supplements you take:
Please briefly describe your diet (food & beverages):
Breakfast:
Lunch:
Dinner:
Other:
If you use caffeine, sugar, alcohol, tobacco, recreational drugs, please briefly describe:
Do you exercise regularly?
Would you generally describe yourself as running hot or cold?
How is your sleep?

FAMILY HISTORY: Check illnesses that have occurred in family. P = Paternal; M = Maternal
High Blood Pressure
Heart Disease
Stroke
Diabetes
Cancer
Auto-Immune
Other
Anything else you wish to share?
HEAD-TO-TOE CHECKLIST: Please check any symptoms you have, or have had within the past year.
HEAD, EYES, EARS, NOSE, THROAT
Headache: areas
Blurred vision/ spots in vision
Eye pain/ infections
Loss of hearing
Ringing in ears
Allergies/ sinus infections
Nose bleeds
Persistent cough
Asthma/ wheezing/ difficulty breathing
Swollen glands
Sore throat

NEUROLOGICAL
Numbness/ nerve pain
Dizziness
Poor memory (short/ long term)
Seizures
SKIN & HAIR
Itching/ Rash: areas
Acne: areas
Sores/ Ulceration
Bruise easily
Dry skin
Hair loss
CARDIOVASCULAR/ RESPIRATORY
High/ Low blood pressure
Rapid/ irregular heart beat
Chest pain/ tightness in chest
Poor circulation: cold hands & feet
Swelling of ankles/ edema
Cough: dry/wet
MUSCULO-SKELETAL
Arthritis
Muscle cramps/ spasms
Muscle weakness
Joint pain
Limited range of motion

SUN & MOON
DISPENSARY
Plant Seeds of Health

GASTRO-INTESTINAL
Belching, gas or bloating
Nausea/ vomiting
Appetite poor/ excessive/ changeable
Indigestion/ acid reflux
Constipation
Diarrhea
Bowel movements 1x/day: more/ less
KIDNEY/ URINARY
Frequent/ urgent urination
Painful/ blood in urine
Kidney infection/ stones
Night-time urination
GYNECOLOGICAL
PMS/ mood changes
Excessive or scanty menses
Irregular cycle/ menstrual pain
Fertility difficulties
Menopause symptoms
OTHER
The information on this form is correct to the best of my knowledge.
SIGNATURE
DATE