SACRED SISTER
HOLISTICS

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Client Intake & Health History Form

Date of Initial Visit _____

Name / Preferred Pronouns _____

Address _____

Phone Number _____ Email _____

Date of Birth _____ Age_____ Sex _____

Occupation _____ Relationship Status _____

How did you hear about me and this work? _____

Reason For Visit

Primary reason for visit today _____

When did you first notice it? _____ What brought it on? _____

What makes you feel better? _____ Worse? _____

What would you like to achieve as a result of our work together? _____

_____

Medical History

Other practitioners or modalities currently working with_____

Current medications, herbs and/or supplements _____

Any known allergies? _____

Surgeries / Procedures: _____

Hospitalizations / Significant Injuries _____

Other relevant personal or family health history _____

_____

Other Medical History

Do you have or have you had…? (Check all that apply)

Past : *Present*	*Past* : *Present*	*Past* : *Present*
☐ ☐ Asthma	☐ ☐ Sore heels when walking	☐ ☐ Cold hands or feet
☐ ☐ Headaches	☐ ☐ Swollen ankles	☐ ☐ Wear glasses or contacts
☐ ☐ Insomnia	☐ ☐ Herniated or bulging discs	☐ ☐ Seizures
☐ ☐ Disturbed sleep	☐ ☐ Hernia	☐ ☐ Cancer
☐ ☐ Frequent colds	☐ ☐ Feeling faint or dizzy	☐ ☐ Depression
☐ ☐ Sinus Infections	☐ ☐ High blood pressure	☐ ☐ Anxiety
☐ ☐ Low Back Pain	☐ ☐ Low blood pressure	☐ ☐ PTSD
☐ ☐ Muscular Tension	☐ ☐ Varicose veins	☐ ☐ Other mental health condition
☐ ☐ Painful or swollen joints	☐ ☐ Hemorrhoids	☐ ☐ Other not mentioned above
☐ ☐ Sciatica	☐ ☐ Skin Issues	
☐ ☐ Numbness of feet or legs		

Digestive & Elimination Health

Do you follow any specific diet or have dietary restrictions? _____

List any food allergies or intolerances _____

Daily intake of Water_____ Caffeine_____ Protein_____ Fruit_____Veggie_____

How frequently do you have a bowel movement? _____

Do you have or have you had…? (Check all that apply)

Past : *Present*	*Past* : *Present*	*Past* : *Present*
☐ ☐ Food cravings	☐ ☐ Abdominal pain	☐ ☐ Thin stools
☐ ☐ Binge eating	☐ ☐ Constipation	☐ ☐ Blood in stool
☐ ☐ Restricting food intake	☐ ☐ Diarrhea	☐ ☐ Mucus in stool
☐ ☐ Bloating after eating	☐ ☐ Incomplete bowel movements	☐ ☐ Other not mentioned above
☐ ☐ Gas after eating		
☐ ☐ Burping after eating		

Past : *Present*	*Past* : *Present*
☐ ☐ Pain or burning with urination	☐ ☐ Interstitial Cystitis
☐ ☐ Frequent urination	☐ ☐ Urinary Incontinence or dribbling
☐ ☐ Urinary tract infection	☐ ☐ Difficulty starting or holding urine stream
☐ ☐ Recurrent UTI	☐ ☐ Nocturnal urination
☐ ☐ Bladder or kidney infections	☐ ☐ Blood or pus in urine
☐ ☐ Urinary retention	

Sexual History

Are you currently in a sexual relationship? _____

How would you rate your interest in sex: High Moderate Low None

Are you satisfied with your level of sexual desire? _____ Any recent changes? _____

Reproductive Health

Do you have or have you had any of the following? (Check all that apply)

Past : *Present*	*Past* : *Present*	*Past* : *Present*
☐ ☐ Increased sex drive ☐ ☐ Decreased sex drive ☐ ☐ Difficulty maintaining an erection ☐ ☐ Pain with intercourse	☐ ☐ Pain or discomfort between scrotum and testicles ☐ ☐ Pain or discomfort in inner thighs (Right, Left or Both)	☐ ☐ Pain or discomfort in: Penis, Testicles, Rectum ☐ ☐ Pain in lower back, especially after intercourse ☐ ☐ Other not mentioned above

If you had a sperm count test, what was date and result _____

If you have had a prostate specific antigen (PSA) test, what was date and result _____

Any family history of prostate disease? _____

Mental & Emotional Health

How do you care for yourself? _____

Are you currently experiencing high levels of stress? _____

How does this affect your life and how do you manage this? _____

Do you have a faith or spiritual practice, and if so, would you be willing to share?_____

_____

What exercises do you enjoy and how often do you do it?_____

_____

Do you use Tobacco? _____ Quantity _____/ppd Marijuana? _____How much? _____

Alcohol? ____ Quantity _____ per day / week / month

Other drugs or substances? _____ What and how often? _____

Do you think you have an addiction to any of these substances? _____

Have you experienced sexual, physical, or emotional trauma or other traumatic events? If yes, please share more about this if you wish to_____

_____

General

Anything else you would like to share with me? _____

_____

_____

_____

_____

_____

_____