

SACRED SISTER
HOLISTICS



Elise Thomson, CNM
elise@sacredsister.com
www.sacredsister.com

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)

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

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)

| | | |
|--|---|---|
| <p><i>Past : Present</i></p> <input type="checkbox"/> <input type="checkbox"/> Food cravings <input type="checkbox"/> <input type="checkbox"/> Binge eating <input type="checkbox"/> <input type="checkbox"/> Restricting food intake <input type="checkbox"/> <input type="checkbox"/> Bloating after eating <input type="checkbox"/> <input type="checkbox"/> Gas after eating <input type="checkbox"/> <input type="checkbox"/> Burping after eating | <p><i>Past : Present</i></p> <input type="checkbox"/> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Incomplete bowel movements | <p><i>Past : Present</i></p> <input type="checkbox"/> <input type="checkbox"/> Thin stools <input type="checkbox"/> <input type="checkbox"/> Blood in stool <input type="checkbox"/> <input type="checkbox"/> Mucus in stool <input type="checkbox"/> <input type="checkbox"/> Other not mentioned above |
|--|---|---|

| | |
|---|--|
| <p><i>Past : Present</i></p> <input type="checkbox"/> <input type="checkbox"/> Pain or burning with urination <input type="checkbox"/> <input type="checkbox"/> Frequent urination <input type="checkbox"/> <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> <input type="checkbox"/> Bladder Infection | <p><i>Past : Present</i></p> <input type="checkbox"/> <input type="checkbox"/> Recurrent UTI <input type="checkbox"/> <input type="checkbox"/> Interstitial Cystitis <input type="checkbox"/> <input type="checkbox"/> Urinary retention <input type="checkbox"/> <input type="checkbox"/> Urinary Incontinence |
|---|--|

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? _____

Pregnancy Health

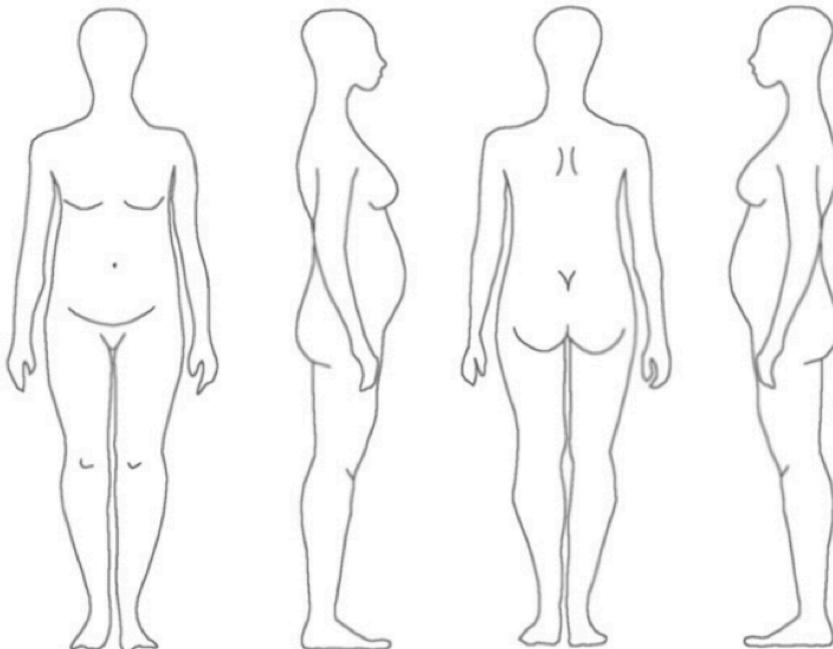
Who is your pregnancy care provider and where do you plan to give birth? _____

Have any pregnancy risk factors been identified for you? Please specify if so _____

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

| | | |
|--|---|---|
| <i>Past : Present</i> <input type="checkbox"/> <input type="checkbox"/> Pelvic pain <input type="checkbox"/> <input type="checkbox"/> Vaginal pain <input type="checkbox"/> <input type="checkbox"/> Carpal tunnel syndrome <input type="checkbox"/> <input type="checkbox"/> Leg cramps <input type="checkbox"/> <input type="checkbox"/> Restless legs <input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting | <i>Past : Present</i> <input type="checkbox"/> <input type="checkbox"/> Irritability <input type="checkbox"/> <input type="checkbox"/> Swelling of hands, feet, or ankles <input type="checkbox"/> <input type="checkbox"/> Yeast infections <input type="checkbox"/> <input type="checkbox"/> Sleep issues | <i>Past : Present</i> <input type="checkbox"/> <input type="checkbox"/> Mood changes <input type="checkbox"/> <input type="checkbox"/> Itchy skin <input type="checkbox"/> <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> <input type="checkbox"/> Elevated blood pressure <input type="checkbox"/> <input type="checkbox"/> Other not mentioned above |
|--|---|---|

Please indicate on these images areas where you are experiencing pain or discomfort:



Pregnancy History

How was conception for you? Easy Unexpected Assisted

Have you had any fertility challenges (past or present)? _____

If yes, please describe any tests or treatments you may have received _____

| | |
|------------------------------------|--|
| # Pregnancies: _____ Dates: _____ | # Terminations: _____ Dates: _____ |
| # Miscarriages: _____ Dates: _____ | # Times giving Birth: _____ Dates: _____ |

Vaginal Births _____ # Cesarean births _____ # Living children _____

Share relevant complications or challenges of any of the above, including during labor, birth or postpartum: _____

How do you feel about giving birth this time? _____

What family or community support do you have for this pregnancy and postpartum? _____

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 _____

If yes, did you have any counseling around this experience? Was it helpful? _____

General

Anything else you would like to share with me? _____
