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	☐ ☐ Recurrent UTI
☐ ☐ Frequent urination	☐ ☐ Interstitial Cystitis
☐ ☐ Urinary tract infection	☐ ☐ Urinary retention
☐ ☐ Bladder Infection	☐ ☐ 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? _____

Pelvic Health

Have you had a pelvic exam before? _____

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

Past : *Present*	*Past* : *Present*	*Past* : *Present*
☐ ☐ Pelvic pain	☐ ☐ Abnormal pap smear	☐ ☐ Endometriosis
☐ ☐ Vaginal dryness	☐ ☐ Sexually transmitted infection (STI)	☐ ☐ Uterine Fibroids
☐ ☐ Vaginal pain	☐ ☐ Polycystic ovarian Syndrome (PCOS)	☐ ☐ Uterine infections
☐ ☐ Pain with intercourse	☐ ☐ Ovarian Cysts	☐ ☐ Uterine or cervical polyps
☐ ☐ Difficulty reaching orgasm		☐ ☐ Other not mentioned above
☐ ☐ Vaginal imbalances		

Menstrual Health

Date of last menstrual period _____ Cycle length _____Age at first period _____

How many days do you bleed?_____ Describe your bleeding: Heavy Medium Light

What menstrual products do you use? _____

Do you chart your cycle? _____ If so, how? App, paper charts?_____

What contraceptive methods do you use? _____

Menstrual Symptoms

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

Past : *Present*	*Past* : *Present*	*Past* : *Present*
☐ ☐ Ovulation pain	☐ ☐ Dark blood at beginning of period	☐ ☐ Irregular menses
☐ ☐ Premenstrual anxiety	☐ ☐ Dark blood at end of period	☐ ☐ Early or late menses
☐ ☐ Premenstrual depression	☐ ☐ Excessive bleeding	☐ ☐ Lack of ovulation
☐ ☐ Premenstrual insomnia	☐ ☐ Light bleeding	☐ ☐ Bleeding/spotting with ovulation
☐ ☐ Heaviness prior to period	☐ ☐ Clots during menstruation	☐ ☐ Painful intercourse with ovulation
☐ ☐ Painful periods	☐ ☐ Dizziness with menses	☐ ☐ Other not mentioned above
☐ ☐ Bloating	☐ ☐ Water retention	
☐ ☐ Headache or migraine with period	☐ ☐ Bowel changes with period	

Fertility & Pregnancy Health

Are you currently hoping to conceive? _____ If so, how long have you been trying?_____

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: _____

_____

Menopausal Heath

At what age did your symptoms begin? _____ Are your symptoms getting: Worse Better Same

When do you experience your symptoms the most? _____

Are you on, or have you ever been on, hormone replacement medication? _____

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

Past : *Present*	*Past* : *Present*	*Past* : *Present*
☐ ☐ Hot flashes	☐ ☐ Mood swings	☐ ☐ Decreased libido
☐ ☐ Vaginal discharge	☐ ☐ Fatigue	☐ ☐ Heavy menses
☐ ☐ Spotting	☐ ☐ Memory loss	☐ ☐ Vaginal dryness
☐ ☐ Insomnia	☐ ☐ Depression	☐ ☐ Painful intercourse
☐ ☐ Disturbed sleep pattern	☐ ☐ Anxiety	☐ ☐ Increased libido
☐ ☐ Irregular menses	☐ ☐ Irritability	

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? _____

_____

_____

_____

_____

_____

_____