

# The Path of Practice & The Alchemy of Herbs

196 S. Main St. #1,  
Newmarket,  
NH 03857

pathofpractice@comcast.net

(603) 659-0396

**INTAKE FORM – All Information Given Is Confidential**  
**Consultant Herbalist: Lona Kovacs**

**Name:** \_\_\_\_\_

**Today's date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone # Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Best time to reach you?** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ lbs

**Occupation:** \_\_\_\_\_

**Passions:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_

**Children (#/ ages):** \_\_\_\_\_

**Share Home with:** \_\_\_\_\_

**Please list all physicians and other healthcare providers or consultants (such as acupuncturist, massage therapist, etc.) you see on a regular basis:**

Name	Location	Type of Service
<hr/>		
<hr/>		
<hr/>		
<hr/>		

**Please list your current health concerns and what you would like help with at this time:**

---

---

---

**When did this begin?**

---

---

**Are you currently taking any medications (prescriptions or otherwise)?** Yes No

**If yes, please list them:**

---

---

**List any herbs, supplements and vitamins you take now, or took previously, on a regular basis (with dates):**

## Lifestyle Questions:

Please circle or fill in the appropriate response. Do you. . .

Exercise regularly? Yes No How many times per week? \_\_\_\_\_ How long? \_\_\_\_\_

What exercise do you do? \_\_\_\_\_

Do you sleep well? Yes No How many hours per night? \_\_\_\_\_

Do you nap? Yes No

Do you like your work? Yes No How many hours per week do you work? \_\_\_\_\_

Are you satisfied with your energy levels? Yes No

What would you describe as the two dominant emotions in you life at this time?:

joy happiness anger sadness fear sympathy worry depression other (please specify)

---

## Your Dietary Habits:

Please check each item listed below if it is included in your daily, or usual, diet:

Red Meat	Milk/Butter	Coffee/Black Tea
Fish	Cheese (Hard/Soft)	Herbal Tea
Poultry	Fermented Foods	Alcohol
Fruits	Yogurt	Seaweeds
Vegetables	Sugar	Vitamins
Raw Foods	Honey	Protein Supplements
Grains (Cooked/Sprouted)	Baked Goods	Food Supplements (‘super-foods’ like spirulina, chlorella, wheat grass, etc.)
Nuts/Seeds	Desserts	

**Do you smoke cigarettes (cigars/pipe/marijuana)?** Yes No

**How many years?** \_\_\_\_\_ **Amount per day?** \_\_\_\_\_

**What do you like about your diet?**

---

**Would you like to change your diet?**

---

**Do you now undertake, or have you undertaken, a restricted diet? Please describe and indicate when:**

---

**Do you have any known allergies or sensitivities? If so, please list them.**

---

### **Your Family History:**

**Has anyone in your family had any of the following? If so, please specify your relation to them.**

Cancer \_\_\_\_\_ Heart disease \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Low Blood Pressure \_\_\_\_\_ Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_

Depression \_\_\_\_\_ Stroke \_\_\_\_\_ Allergies \_\_\_\_\_

Headaches \_\_\_\_\_ Joint Disease \_\_\_\_\_ Congestive Heart \_\_\_\_\_

Mental Illness \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Thyroid Problems \_\_\_\_\_

Other (please specify) \_\_\_\_\_

**General Health Concerns:**

Please check off if you have experienced any of these *in the last three months*:

**Skin and Hair**

Rashes    Itching/Dryness    Boils    Bruises    Dandruff    Loss of hair  
Skin change in texture    Eczema/Psoriasis    Hives    Headaches    Joint Disease  
Congestive Heart    Mental Illness    Tuberculosis    Thyroid Problems    Recent moles  
Varicose Veins    Pimples    Skin eruptions    Itching    Poor healing sores  
Other (please specify) \_\_\_\_\_

**Cardiovascular**

High Blood Pressure    Chest Pain    Irregular Heartbeat  
Low Blood Pressure    Poor Circulation (cold hand and feet?)    Fainting  
Swelling ankles/ joints    Previous heart stroke/murmur  
Other (please specify) \_\_\_\_\_

**Muscles/Joints**

Backache/upper or lower    Muscle pain    Stiffness  
Broken Bones    Muscle Weakness    Mobility Restriction  
Arthritis /Bursitis  
Other (please specify) \_\_\_\_\_

**Respiratory**

Cough    Bronchitis    Asthma    Coughing Blood    Pneumonia  
Shortness in Breath    Chest Pain    Difficulty in breathing  
Production of phlegm    If yes, what color? \_\_\_\_\_  
Other (please specify) \_\_\_\_\_

## **Urinary/Kidney**

Pain in urination    Water retention    Blood in urine    Frequent urination

Kidney stones    Irregular flow    Urgency of urination    Burning urine

Inability to hold urine    Dark circles under the eyes    Decrease in flow    Lower back pain

Itchy ears/eyes    Difficulty starting/stopping flow    Emotional insecurity

## **Gastrointestinal**

Nausea    Belching    Vomiting    Colitis    Diarrhea    Constipation

Abdominal Pain    Black Stools    Liver Problems    Blood in stools

Bad breath    Indigestion    Gall stones    Ulcers    Heartburn

Mucous in stools    Rectal pain    Hemorrhoids    Gas    Bloating

Food Cravings    Poor appetite    Difficulty swallowing

Other (please specify) \_\_\_\_\_

Number of bowel movements per day \_\_\_\_\_

**Type:** Loose    Normal    Hard

## **Head, Eyes, Ears, Nose, & Throat**

Ear Aches    Poor vision    Eye pains, Dry/Wet    Cataracts    Hay fever

Glaucoma    Sinus infection    Poor hearing/hearing loss    Ringing in ears

Sinus congestion    Sore throat    Tonsil Pain    Canker sores    Cold sores

Grinding teeth    Nose bleeds    Facial pain    Clicking jaw    Eye pain

Mucous in throat    Swollen glands    Ear infections    Dizziness    Frequent colds

Spots in front of eyes

Other (please specify) \_\_\_\_\_

## **Neuropsychological**

Poor sleep    Poor memory    Numbness    Depression    Irritability    Anxiety

Seizures    High stress levels    Difficulty concentrating    Foggy or spacey

Lack of coordination    Loss of balance

Other (please specify) \_\_\_\_\_

## **Headaches**

**Do you often have headaches?** Yes No

**How often do you have them?** \_\_\_\_\_

### **Location/type of headache:**

Migraine    Morning    Front of head    Sharp    Chronic    Afternoon

Around eyes    Dull    Cluster    Evening    Around head    Throbbing

Night    Back of head    Pounding    Before eating    After eating

Light but constant    Temples Left side    Right side

Aversion to stimuli

Other (please specify) \_\_\_\_\_

## **Men**

Burning on ejaculation    Penis discharge    Swelling in testicles    Pain in testicles

STDs    Vasectomy    Dribbling    Impotence    Low vitality

Prostate pain    Blood in urine    Blood in semen

**Do you have trouble maintaining an erection?** Yes No

**Women General:**

Breast pain/lump    Endometriosis    Fibroids    Ovarian or other cysts

Unusual PAP    Painful intercourse    Vaginal dryness    Painful intercourse  
Infertility    STD's    Vaginal wetness    Miscarriage    Cesarean sections

Live births    Estrogen therapy    Abortions    Cervical Dysplasia

Pelvic inflammatory disease

Vaginal infection    **How long?** \_\_\_\_\_ **What type?** \_\_\_\_\_

Vaginal itching/discharge    **How long?** \_\_\_\_\_

Breast lump/pain    **When in your cycle?** \_\_\_\_\_

**Does it change in your cycle?**    Yes    No

**List each pregnancy you've had, including miscarriages and abortions:**

Pregnancy/Date	Miscarriage/Date	Abortion/Date

**Menstrual:**

Age at onset    Regular cycles    Cycle number of days    Number of days flowing

Clotting    Red blood    Brown blood    Flow L M H    Pain/Cramps    Bloating

Irritability    Breast tenderness    Acne at menses    Irregular cycles    Hot flashes

Date of last pelvic exam and PAP? \_\_\_\_\_

**Birth Control:**

**Please check and give dates for all that you have used *in the last ten years*:**

Oral contraceptives    IUD    Depro-provera    Condoms    Norplant

Diaphragm    Fertility awareness    Spermicide    Birth Control Pills

Other (please specify) \_\_\_\_\_

**Are you currently sexually active?** Yes No

**Menopause:**

Hot flashes    Dry vaginal lining    Break through bleeding    Dramatic mood swings

Osteoporosis    ERT Therapy

Please list major events in the last 7 years of your life, and the dates they occurred; this includes births, deaths, marriage, divorce, accidents, moves, job changes, miscarriages, illness, and anything else you feel greatly impacted your life.

**Dates**

**Events**

---

---

---

---

---

---

---

---

---

---

**Notes:**

---

---

---