# Troy Farwell Holistic Health

Intake Form

Date:_____

NAME:_____ EMAIL_____

SEX:_____ BIRTHDATE:_____ AGE:_____ HEIGHT_____ WEIGHT_____

**Health Problems**

#1 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

---

#2 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

---

#3 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

_____

#4 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

# Troy Farwell Holistic Health

Intake Form

Are you currently receiving care from any other health professional(s)? (Please provide names) Please list all supplements and prescription drugs below:

Is there any chance that you are pregnant? ☐Yes ☐No

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc)?

Is there any reason you cannot ingest herbal remedies prepared in food grade alcohol? ☐Yes ☐No

Have you ever undergone surgery or been hospitalized? (Please provide the date and reason)

Please describe any accidents or injuries you have sustained in the last five years:

## Family Medical History

*Please complete this section only for any family members with particular health problems.* Relationship
Age (if deceased, age at death) Health issue
Mother -
Father - Siblings
- Children -
Grandmother -
Grandfather - Other:

## Personal Health Habits

Weight 1 year ago: _____ Weight in your early 20's: _____ Goal Weight?_____
Are you a smoker? _____ Years? _____ Amount? _____
Have you smoked in the past? _____ When did you quit?_____
Do you exercise regularly? _____ Frequency? _____times/week
Type? Cardio_____Yoga_____ Strength_____
Do you use recreational drugs? _____ What types? _____ How often_____
Do you drink alcohol?_____How often? _____What Kind?_____How much? _____

# Troy Farwell Holistic Health

Intake Form

## DIET

Do you drink warm or cold water?_____

Do you drink coffee? ☐Yes ☐No How often? _____ What kind? _____

Do you drink tea? ☐Yes ☐No How often? _____times/week. What kind? _____

To the best of your ability, please indicate what you typically eat on a daily basis (please be honest):

| |
|---|
| Breakfast: *what time?* |
| Lunch: *what time?* |
| Supper: *what time?* |
| Snacks: |

Do you indulge in sweets and desserts? Yes No How often? _____times/week. How much? _____ servings/week.

Do you now or have you ever followed a restricted diet? Please describe and indicate when:

Rate the strength of your appetite on a scale 1-100._____

Rate the strength of your digestion on a scale 1-100._____

# Troy Farwell Holistic Health

Intake Form

## PART TWO: HEALTH CONCERNS

Please check those issues you have experienced in the last 3 months.

**Skin and Hair**

☐Rashes

☐Poor healing sores

☐Hives

☐Itching

☐Eczema

☐Psoriasis

☐Pimples

☐Acne

☐Dandruff

☐Hair Loss

☐Recent moles

☐Recent changes in skin texture

Any other noted problems with your skin, nails or hair?

**Head, Eyes, Ears, Nose and Throat**

☐Poor vision

☐Floaters

☐Cataracts

☐Glaucoma

☐Blurred vision

☐Eye pain

☐Earaches

☐Poor hearing

☐Ringing in ears

☐Sore throat

☐Canker sores

☐Cold sores, if yes how often? _____times/year

☐Grinding teeth

☐Facial pain

☐Jaw pain

☐Mucous in throat

☐Nosebleeds

☐Dizziness

☐Frequent colds

☐Swollen glands

Any other problems with your head, eyes, ears, nose or throat?

**Cardiovascular**

☐High blood pressure

☐Low blood pressure

☐Chest/heart pain

☐Fainting

☐Irregular heart beat

☐Cold hands or feet

☐Ankle swelling

☐Palpations

☐Easy bruising

☐Varicose veins

☐Blood clots

☐Breathing difficulties Any other problems with your heart or circulation?

**Gastro-Intestinal**

☐Nausea

☐Vomiting

☐Diarrhea

☐Constipation

☐Bad Breath

☐Indigestion

☐Abdominal Pain

☐Heartburn

☐Gas

☐Blood in stools

☐Mucus in stools

☐Rectal pain

☐Hemorrhoids

☐Bloating

☐Food cravings

# Troy Farwell Holistic Health

Intake Form

☐Gallstones

☐Ulcers

☐Difficulty swallowing

☐Colitis/IBS

☐Liver Problems

How many bowel movements do you have per day?
<1 1 2 3 4 +

How would you describe your bowel movements?

Any other digestive problems?

**Respiratory**

☐Hayfever

☐Cough

☐Bronchitis

☐Asthma

☐Coughing blood

☐Pneumonia

☐Pain on breathing

☐Shortness of breath without exertion

☐Difficulty breathing when lying down

☐Production of phlegm, if yes what color?_____ Any other problems with breathing?

**Genito-urinary**

☐Painful urination

☐Frequent urination

☐Blood in urine

☐Urgency of urination

☐Kidney / bladder stones

☐Irregular flow

☐Inability to hold urine

☐Decrease in flow

☐Water retention

☐Burning urine

☐Difficulty stopping or starting

☐Prostate enlargement

☐Interstitial crystals

☐Erectile dysfunction

Any other problems with urination?

**Musculoskeletal**

☐Neck pain

☐Muscle pain

☐Stiffness

☐Back pain

☐Muscle weakness

☐Broken bones

☐Reduced range of movement

Do you see a Chiropractor or Massage Therapist? (Please provide name).

Any other musculoskeletal problems?

**Female reproductive**

☐Discharge

☐Genital herpes

☐Cervical dysplasia

☐Endometriosis

☐Uterine cysts

☐Fibroids

☐Vaginal itching

☐Anemia

☐Pelvic inflammatory disease

☐Infertility

☐Hysterectomy

☐Pain with intercourse

☐Tubal ligation

☐Mastectomy

☐Lumpectomy

☐Vaginal infection

Do you menstruate? ☐Yes☐No

If yes, what is the length of your cycle (period to period):_____days, and the duration of bleeding _____days?

How would you characterize the flow of your cycle?

☐Heavy ☐Normal ☐Light

# Troy Farwell Holistic Health

Intake Form

Is the blood? ☐Dark ☐Normal ☐Light

Do you have premenstrual symptoms? How many days before your cycle do symptoms begin to manifest? _____ days before period If you have PMS, which symptoms apply to you?

☐Breast tenderness

☐Bloating

☐Weight gain

☐Water retention

☐Depression

☐Poor memory

☐Confusion

☐Insomnia

☐Lower back pain

☐Abdominal pain

How many: pregnancies have you had? _____; births? _____ ; miscarriages?_____; premature births?____; abortions? _____

If you have menopausal symptoms, please describe your major symptoms:

Do you or have you recently used contraceptives? ☐ Yes ☐No If yes what kind? _____

Are you post-menopausal? ☐Yes ☐No

If yes what is the approximate date of your last period? Do you have any other gynecological issues?

**Neuropsychological**

Have you ever been diagnosed with a mental health condition?
If so what and when?
Have you ever been hospitalized for any mental health condition?

☐Poor sleep

☐Poor memory

☐Numbness, if yes where? _____

☐Depression

☐Irritability

☐Anxiety

☐Seizures

☐Migraine

☐Headaches

☐High stress levels

☐Loss of balance

☐Lack of coordination

☐Difficulty concentrating

☐Foggy or spacey feeling

☐Muscle spam/twitching

How many hours do you sleep each night? _____

# Troy Farwell Holistic Health

Intake Form

What time do you go to bed? _____
What time do you awake?_____
How do you sleep? (on back, what side, stomach)

Do you have any other neurological problems?

**Mind and Emotions**

Are you able to express your feelings and emotions easily? ☐Yes ☐No

Is there an excess of stress in your life? ☐Yes ☐No If so what is causing you so much stress?

Do you have tools or techniques to relieve stress? ☐Yes ☐No

Do you meditate? ☐Yes ☐No How
often, what style?

## Recommendations

**1.**
**2.**
**3.**
**4.**
**5.**
**6.**
**7.**
**8.**
**NOTES:**