



**Alexandra Williams
Clinical Herbalist**

**Informed Disclosure
Client No.**

My goal is to give people the skills to know their bodies and the agency to make their own decisions from a place of empowerment. My goal is not to be another authority figure, or to take responsibility for your health.

I am not a doctor.

I am an herbalist and an educator.

Herbally, I work in a holistic paradigm. Nutritionally, I work with the principles of traditional nutrition, ancestral nutrition, and slow food. In all cases, my primary goal is to help you nourish and support your body so that it can heal itself.

I am happy to provide you with information and research in writing that you can discuss with your other healthcare providers at any time. You should notify your physician(s) of any herbs or supplements you are using. It is your responsibility to notify me of any prescription medications you are using.

Herbs work over time; however, if at any time you don't feel happy with any recommendations, or if you feel you might be having an adverse reaction, please let me know and we will work to find something that you are comfortable with.

Good health is your own personal responsibility: the final decision in any recommendation – whether to follow it or not – is always yours.

The nature of this appointment is educational: it is important to me that you have a good understanding of what we discuss, no matter how many questions you need to ask or how long it takes us to get clear.

Please sign to indicate you have read and understood this information:

name

date



**Alexandra Williams
Clinical Herbalist**

**Intake Form
Client No. 0002**

Name:

Contact information:

DOB:

gender:

weight:

height:

occupation:

current health care practitioners:

prescription meds / herbs / supplements:

OTC meds / herbs / supplements:

adverse reactions:

Complaints

primary complaint[s]:

symptom scores (10 = worst):

secondary complaint[s]:

relevant lab work / medical diagnosis:

Diet

diet style:

typical breakfast:

typical lunch:

typical dinner:

what kind of snacks do you normally eat?
what do you crave?
do you have any known sensitivities?
what are your flavor preferences?
how do you prefer to prepare your food?
home-prep frequency:
do you drink caffeine? in what form? how much per day?
do you drink soda? if so, how much?
do you drink alcohol? in what form? how much?
how do you fulfill your sweet tooth? how many sweets per day?
do you eat out? if so, how often?
how many fruits and vegetables do you eat per day? which ones?
do you eat meat? how often? what kind?
do you eat soy? how often? what kind?
do you eat dairy? how often? what kind?
comments:

Medical history

personal medical history:
tobacco:
recreational drugs:
allergies:
family medical history:

Digestive

symptoms (mark all that apply): dry mouth, heartburn, acid reflux, GERD, somtach ulcer, nausea, dyspepsia, bloating, constipation, diarrhea, flatulence, parasites, dysbiosis, SIBO, celiac disease, Chrohn's disease, IBS, IBD, ulcerative colitis

how often do you have a bowel movement? what are the characteristics?

Comments:

Kidney / urinary

symptoms (mark all that apply): UTI, kidney stones, frequent urination, poor bladder control, pain
how often do you urinate? what color is it?

Comments:

Respiratory

symptoms (mark all that apply): cold or flu, strep throat, bronchitis, pleurisy, sinusitis, asthma,
smoker's lung

comments:

Energy / stress

symptoms (mark all that apply): chronic fatigue, insomnia, anxiety, depression

favorite time of day:

favorite time of year:

favorite weather:

do you exercise? how often? in what form?

how many hours do you sleep per night?

how do you handle pressure?

can you identify any weak points in your handling of pressure

current stressors:

comments:

Cardiovascular

symptoms (mark all that apply): high blood pressure, palpitations, coronary artery disease, angina,
heart attack, arteriosclerosis, atherosclerosis, stroke, poor circulation, varicose veins

blood pressure: resting heart rate:

total cholesterol:

HDL:

LDL:

Comments:

Immune

symptoms:

immunizations received:

do you have any chronic conditions?

comments:

Endocrine

symptoms (mark all that apply): diabetes (type 1 or type 2), ketoacidosis hyperthyroid, hypothyroid, chronic fatigue, carb-cravings, unexplained weight gain, unexplained weight loss, PCOS, metabolic syndrome, systemic inflammation

fasting blood glucose:

comments:

Nervous

symptoms (mark all that apply): ADD/ADHD, Multiple Sclerosis, fibromyalgia, neuropathy, Bell's palsy, Parkinson's, restless leg, epilepsy, Alzheimers, anxiety, insomnia, depression, schizophrenina, Tourette's, bipolar, pain

how often to these symptoms occur?

have you noticed any aggravating factors?

comments:

Musculoskeletal

Symptoms (mark all that apply): delayed onset muscle soreness, chronic back pain, arthritis (osteo or rheumatoid), carpal tunnel, pelvic floor disorder, plantar fasciitis, osteoporosis, dystrophy, fibromyalgia, gout, inflammation

comments:

Reproductive

symptoms: UTI, bacterial vaginosis, yeast infection, HPV, impotence, prostatitis, BPH, incontinence, uterine prolapse, PCOS, endometriosis, polyps, fibroids, cysts, delayed menses, overheavy bleeding, absent period, PMS

do you have a menstrual cycle?

duration:

frequency:

regularity:

flow:

clotting:

history of pregnancy and labor:

results of last gynecological exam / pap smear:

comments:

Social / emotional / spiritual

what are your predominant emotions?

how do you feel in relation to others?

how is your relationship with your family?

how are your relationships with friends?

do you have a partner? how do you feel in your partnership?

tell me a little about your community:

tell me a little about your support network:

what do you do for fun / relaxation?

what have you always wanted to be:

do you have a spiritual practice?

comments:

Clinician's assessment

long-term plan:

initial protocol:

dietary recommendations:

herbal recommendations:

info given:

follow-up thoughts:

clinician's insights: