Client Intake Form

Harmony Holistic Health

Client Information

Full Name: _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Address:

_____

Phone Number: _____ **Email:** _____

Emergency Contact Name: _____ **Phone:** _____

General Health

Primary Reason for Seeking Holistic Healthcare:

List any current health conditions or diagnoses:

List any medications (prescription and over-the-counter) and supplements you are currently taking:

Allergies (medications, food, environmental):

Past surgeries or hospitalizations:

Lifestyle and Wellness

Dietary Habits (please describe a typical day of eating):

Exercise Habits (frequency, type):

Sleep Patterns (hours per night, quality of sleep):

Stress Levels (how do you typically manage stress?):

Do you smoke? □ Yes □ No **If yes, how many per day?** _____

Do you drink alcohol? □ Yes □ No **If yes, how often?** _____

Do you use recreational drugs? □ Yes □ No **If yes, please specify:** _____

Herbal Support

Have you used herbal remedies before? □ Yes □ No

If yes, please list any herbs you have used and your experience with them:

Are you interested in using herbal remedies as part of your holistic health plan? □ Yes □ No

Are you aware of any contraindications with herbs and your current medications or conditions? □ Yes □ No □ Unsure

If yes, please specify:

Additional Information

Please use this space to provide any additional information you feel is relevant to your health and wellness goals:

What are your specific goals for working with Harmony Holistic Health?

Client Signature: _____ **Date:** _____

Disclaimer: This information is confidential and will be used to develop a personalized holistic health plan. It is not a substitute for professional medical advice. Please consult with your doctor or other qualified healthcare provider if you have any questions about your health.