Errant Empire Herbal Medicine Dispensary & Clinic
1316 Esquimlat Road
250.590.5035
david@errantherbal.com

Name:_____
Date of Birth:_____
Biological sex:_____
Phone Number:_____
Address:_____
Email:_____

Do you wish to receive occasional email updates? Y / N

Emergency Name and Contact Number:

Doctors Name and Contact Number:

Main diagnoses, concerns, symptoms:

Your past diagnoses or other significant health issues:

Current prescriptions/medications/supplements & Doses:

Allergies:

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Previous Surgeries / Hospitalizations:

Childhood diseases and syndromes:

Indicate all that apply about your birth and infancy and childhood:

_Allergies _Asthma _Atopic eczema _Tonsilitis
_Bronchitis _Mononucleosis _Whooping Cough _Born preterm
_Born full term _Breastfed _Formula fed _Many antibiotics
_Birth complications_____
_Repercussions from any childhood infections?_____
_Vaccines_____

******The remainder of the intake form is very useful for our work together, but some questions may not pertain to your condition. These questions assist in identifying patterns in your health related to connections between ailments and undiagnosed conditions.***

Describe your stress levels:

Body temperature and Energy:

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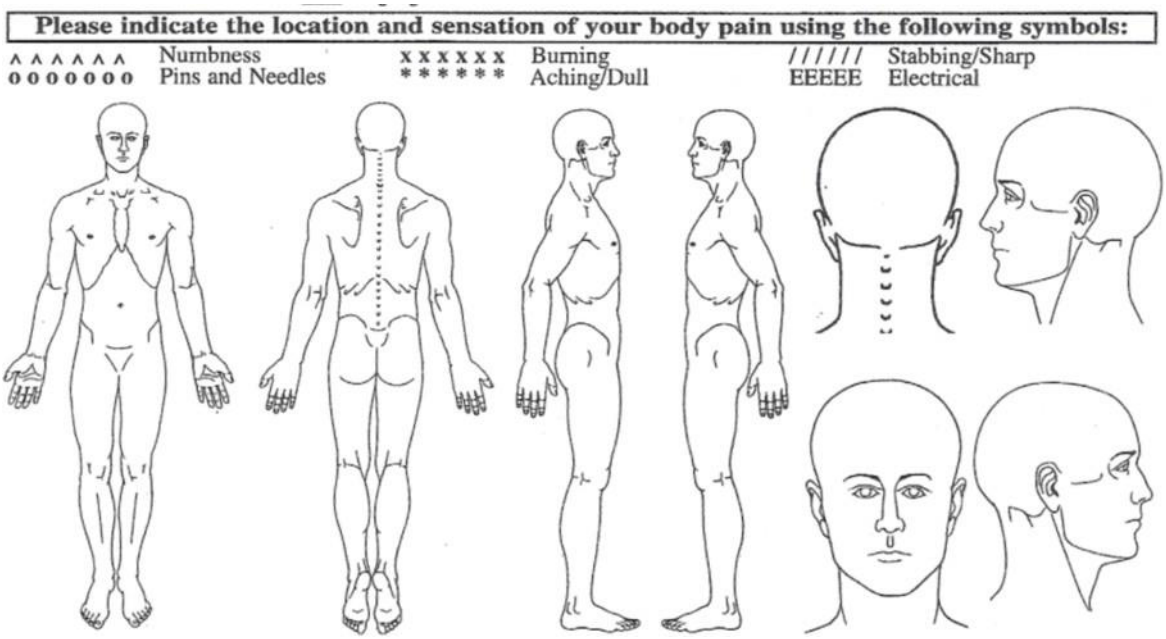

Exercise: (Type, Frequency)

Hobbies: (Interests that make you happy, calm and engaged)

Health History: Please select all that apply.

___ADD/ADHD ___Alcoholism ___Allergies ___Anemia ___Bruxism
___Cancer ___Chemical sensitivities ___Chronic Fatigue ___Diabetes
___Dizziness ___Drug use ___Epilepsy ___Eyesight issues ___Headacheas
___Hepatitis ___High Blood Pressure ___High Stress ___Hyper/Hypo Thyroid
___Hyper/Hypoglycemic ___Immune Issues ___Low Blood Pressure ___Memory issues ___Menopause Issues
___Menstrual Pain ___Microbiome Issues ___Measles ___Mononucleosis ___Mumps
___Recurring Infection ___Seizures ___Shingles ___Shortness of breath ___Sleep problems
___Swelling ___Tumours ___Urinary Tract Issues
___Other_____
_____
_____

Menses / Moon Cycle:

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Is your cycle regular or irregular?_____Age menses began:_____
Average number of days of bleeding:_____Formerly on oral contraceptive pill?_____ Approximate length of full cycle (including menses and in between):_____

Pregnancy:

Number of Full term births?_____ Number of Pre-term births?_____
Health Complications during pregnancy
___Gestational Diabetes ___Anemia
___Pre-eclampsia ___Eczema/Hay fever

Lifestyle:

Relationship status:_____
Do you live with other people:_____
Do you have any children:_____