Maria Falce
Practicing Community Herbalist, Craniosacral Therapist
Kindred Root Intake Form

Name:_____

Address: _____

_____

Telephone: (w)_____ (h) _____

Email:_____Preferred form of contact: _____

Occupation: _____Gender _____Pronouns:_____

Age: _____ Birth date: _____Birth Time_____Birth Location_____

Relationship Status: _____

Number of children: _____ Age(s): _____

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

Would you like me to contact them regarding your health plan with me?_____

Family Medical History:

Please describe any relevant or major health-related issues:

Father: _____

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Other family members with pertinent issues, or recurring family health trends:

_____

_____

PRESENT HEALTH STATUS

Do you currently smoke tobacco (y/n)? _____ If so, how many cigarettes/day? _____

If not, have you ever been a smoker in the past (y/n)? _____

For how many years did you smoke? _____When did you quit? _____

Do you currently drink alcohol (y/n)? _____ If so, list type, quantity, and frequency:

_____

Did you consume alcohol in the past (y/n)? _____ When did you quit alcohol? _____

If so list type, quantity and frequency:_____

List form and frequency of any regular exercise: _____

How is your digestive system overall, do you experience indigestion, gas, constipation, diarrhea, bloating or other? _____

_____

How often do you have a bowel movement? _____

How often do you urinate and what is the character of your urine, i.e., light, dark, strong odor?

_____

Present Health Status

Check each column where symptoms apply and elaborate in space provided below if necessary.

Please indicate with one √ for any experiences below that you sometimes experience; two checks √√ for those which occur often; and three checks √√√ for those which are a major concern.

Cardiovascular

_____High Blood Pressure

_____Low Blood Pressure

_____Pain in Heart

_____Poor Circulation/cold extremities

_____Swelling in Ankles/joint

_____Varicose Veins

_____Previous heart stroke/murmur

____ High Cholesterol

Skin

_____Boils

_____Bruises

_____Dryness

_____Itching

_____Skin Eruptions

Muscles/Joints

_____Backache/upper or lower

_____Broken Bones

_____Mobility Restriction

_____Arthritis/Bursitis

Respiratory

_____Chest Pain

_____Difficulty breathing

_____Cough

_____Tuberculosis

_____Congestion

Eyes, Ears, Nose, and Throat

_____Asthma

_____Ear Aches

_____Eye Pains, Dry/Wet

_____Failing vision

_____Hay Fever

_____Sinus Infection

_____Sinus Congestion

_____Sore Throat

_____Tonsils

_____Hearing Loss/Ringing Ears

Gastro-Intestinal

_____Belching

_____Colitis

_____Constipation

_____Abdominal Pain

_____Liver Problems

_____Gall Stones

_____Ulcers

_____Indigestion

Sleeping Patterns

_____Insomnia

_____Waking in the night

_____Nite sweats

_____Restless sleep

_____Wake up tired

_____Difficulty falling back to sleep

_____Dark circles under eyes

Urinary/Kidney

_____History of UTI

_____Excessive Urination

_____Water Retention

_____Burning Urine

_____Kidney Stones

_____Lower Back Pain

Miscellaneous

_____Itchy Ears/eyes

_____Usually feel Hot/Warm

_____Emotional Insecurity

_____Usually feel Cold/Cool

Do you have headaches?_____How often?_____What are they like?_____

_____

Do you know what causes them?_____

Common Physical Activities

__Desk Sitting (how long)

__Sitting in a car (how Long)

__Calisthenics

__Swimming

__Walking

__Tai Chi

__Bike Riding

__Tennis

__Standing (how long?)

__Jogging/Running

__Aerobics

__Weight Lifting

__Yoga

__Hiking

__Horseback Riding

__ BendingLifting

__Other_____

Do any of the conditions above aggravate a current health condition?_____

Have you had any operations? ____What type & year? _____

_____

Any major injuries/accidents?____ What and when? _____

_____

If yes, what treatment/s did you receive? _____

Any major illness or hospitalizations? ___What and when? _____

_____

DIETARY INFORMATION

Please check each item listed below if it is included in your daily - or usual - diet (mark D=daily, W=weekly, M=monthly, N=never):

___Red Meat

___Candy bars/chocolate

___Milk

___Poultry

___Black Tea

___Yogurt

___Vegetables

___Alcohol

___Honey

___Grains

___Protein Supplements

___Deserts

___Seeds

___Processed foods/snacks

___Crackers

___Butter

___Fish

___Coffee

___Cheese

___Fruits

___Herbal Tea

___Sugar

___Raw Foods

___Vitamins

___Baked Goods

___Nuts

___Food Supplements

___Chips

___Fermented Foods

Dietary Information

Describe below your typical meals. Please be as specific as possible. For example, Instead of "oil" list type of oil, such as olive, corn, etc. Instead of "bread" list whether white or whole grain, etc. Instead of "vegetables" list type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include beverages, type and quantity (two cups of coffee, one glass of orange juice, etc.)

What's a good day of eating like?

Breakfast: _____

_____

A.M. snack(s): _____

Lunch: _____

_____

P.M. snack(s): _____

Dinner: _____

_____

Evening snack(s): _____

Daily water consumption (# glasses/quantity/day): _____

What's a bad day of eating like (meals on the run, etc):

Breakfast: _____

_____

A.M. snack(s): _____

Lunch: _____

_____

P.M. snack(s): _____

Dinner: _____

_____

Evening snack(s): _____

Daily water consumption (# glasses/quantity/day): _____ Filtered or tap?_____

How many times a week do you have a good day_____Bad day_____of eating?

Please list any known food allergies/sensitivities (attach additional sheets if needed):

Food Describe Reaction

_____

_____

_____

If everything was good for you, what would you want to eat (What do you crave)?_____

_____

Current State of Emotions and Feelings

Please take a moment to answer the following questions:

Are you able to express your feelings and emotions? _____

Is there an excess of stress in your life? _____

What is causing the stress?_____

Are you satisfied with your job? _____

If in a relationship, are you satisfied with it?_____

If there is one thing in your life you would like to change right now, what is it?_____

_____

Can you change it?_____

Are you a "nervous type" person? _____

What are the things that make you most nervous?_____

Have you a "super woman/superman" complex?_____

Do you sleep well?_____How long each night?_____

Do you nap?_____ How long and often?_____

Do you dream?_____ Do you remember your dreams?_____

Are you satisfied with your general energy level?_____

Do you often feel exhausted and fatigued?_____

Is it easy to wake up in the morning?_____

Which of these feelings dominate in your life:

joy happiness anger sadness fear sympathy worry depression

If you were to choose two Emotions, which seem predominant in your life they would be_____and_____

Please indicate approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residents, injury, death, etc.)

Year Event

_____

_____

Name one thing in life that you do that is really good for you:_____

_____

Resources. List a few things that comfort you. Can be thiings you do, places, people, pets. Please list both internal (from within you) and external:_____

_____

What are your passions and interests?_____

_____

What do you do for fun?_____

Supplements and Medications

List all herbs, vitamins, and dietary supplements you currently take, Citing brand name whenever possible (please bring all your supplement bottles with you for your appointment):

Use additional paper if needed

Supplement Dosage

_____

_____

_____

_____

_____

List all medications you are currently taking and what they are taken for (including aspirin, antacids, etc.), indicating whether they are over the counter (OTC) or prescription (P):

Use additional additional paper if needed

Name of Product/used for OTC or P? Dosage Frequency (#/day)

_____

_____

_____

_____

_____

_____

Do you use any other drugs? Circle any that apply:

marijuana mushrooms ecstasy cocaine LSD heroin other:_____

Have you used any drugs in the past? Circle any that apply:

marijuana mushrooms ecstasy cocaine LSD heroin other:_____

List all medications, herbs, etc., to which you have a known allergy:

_____

What are the areas of current complaint that you would like to address with an herbal program?

_____

Kindred Root
STATEMENT OF PRACTICE

The human body has the innate power to heal itself. Without this power to self-heal, even the most advanced medications and surgical procedures would ultimately fail. My role in this healing process is to consider the client as a whole person and to consult with the client concerning changes in lifestyle, diet, and supplementation of herbs to foster an increased state of balance and health, thus maximizing the body's self-healing capabilities.

I practice an integrative form of assessment and healing which includes Biodynamic Craniosacral Therapy, nutritional assessment, and energy reading as well as working with the rest of your healing team (if desired) to create a treatment plan to optimize your wellness.

The degree of incorporation of these systems will vary from case to case. The basic principle is to help the body's natural capacity to restore balance, health, and harmony. Assessments are focused on identifying patterns and imbalances. Depending on the patient's wishes, recommendations may incorporate nutrition, herbs, supplements, counseling, exercises and lifestyle. Recommendations may be use to instill physical, emotional, mental, and/or spiritual balance.

I am NOT a Medical Doctor nor do I practice western medical assessment, diagnosis, or treatment. I do not claim to cure disease. Nor do I give advice about pharmaceuticals and medications at any time. I have no objections to my clients being seen or evaluated by their own medical doctor. If you have any questions or concerns about your condition, I highly recommend you discuss it with your physician. I am willing to work as part of a health care team including physicians and other health care providers. If you would like me to work with your physician, please inform you physician also of this wish. I also recommend you inquire and explore any recommendations I provide with any professionals in health care.

Further, I have a herbal/nutritional apothecary in the clinic. I sell many herbal products for a profit. I dispense them here as a convenience and to ensure patients are receiving the specific, individualized herbal formula they need. I make all of the formulations myself and grow or wildcraft as many of the plants as I can, utilizing mostly regional herbs. What I do not grow, I purchase certified organic. Clients are not obligated to buy any products here. I encourage clients to buy any supplements wherever it is most convenient for them. The recommended nutritional/herbal supplements are not a replacement for the medications prescribed by your Medical Doctor.

Please sign below once you have read and understood

Name (print)_____ Date: _____
Signature_____

Due to HIPPA privacy regulations, your information will be held confidential and not shared with anyone.

If you are interested in receiving mailings about lectures, workshops, etc., please provide your mailing address, email, and phone number. Please fill out all areas that we may contact you.
Mailing Address (with Zip): _____
_____
Phone Number:_____ Email:_____
Referral Source:_____

Basic constitutional quiz

Hot/Cold

1. I tend to feel warmer than others y/n
2. I tend to have a loud voice y/n
3. My entire face can easily get red or flushed y/n
4. My tongue tends to be bright red y/n
5. I have a strong appetite y/n
6. I have lots of opinions and I'm not afraid to share them y/n
7. I prefer cold weather y/n

Total yes responses _____

1. I tend to feel colder than others y/n
2. I tend to have a quiet voice y/n
3. My face, lips and/or tongue tend/s to be pale y/n
4. I tend to have a smaller appetite y/n
5. I prefer warm drinks y/n
6. I often feel like I have low energy levels y/n
7. I prefer warm weather y/n

Total yes responses _____

Damp/Dry

1. I tend to sweat more easily than others y/n
2. I often have a runny nose y/n
3. My arms and legs can feel heavy y/n
4. I tend to have a thick coating on my tongue y/n
5. My skin and hair are often oily y/n
6. I prefer dry climates and don't like humidity y/n

Total yes responses _____

1. My skin tends to be rough and dry y/n
2. I often have a dry throat, nose and/or mouth y/n
3. It's hard for me to stay hydrated y/n
4. My hair tends to be dry y/n
5. My tongue does not usually have a coating on it y/n

Total yes responses _____