

# Rookery Herbal

*Traditional Healing with Plants*

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## Short Intake Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Consultation: \_\_\_\_\_ Relationship Status: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary Health Care Provider (GP or Specialist) Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Current Health Information

1. What are your current medications (including herbal, supplements, OTC, and prescription)? ***Please include dosage and frequency:***

2. Do you have any preexisting medical conditions or diagnoses? (Please check all that apply):

☐ Cardiovascular issues (e.g., high blood pressure, heart disease) ☐ Respiratory issues (e.g., asthma, COPD) ☐ Gastrointestinal issues (e.g., IBS, ulcers, Crohn's) ☐ Autoimmune disorders (e.g., lupus, rheumatoid arthritis) ☐ Mental health concerns (e.g., anxiety, depression, bipolar disorder) ☐ Chronic pain conditions (e.g., fibromyalgia, migraines) ☐ Liver/kidney issues (e.g., cirrhosis, CKD) ☐ Diabetes ☐ Thyroid issues ☐ Other: \_\_\_\_\_

Please give brief detail about these conditions/diagnoses (onset, treatment, is it currently well managed etc):

3. Do you have any known allergies (including medications, food, or herbs)?

### **Lifestyle & Health Status**

4. How often do you have a bowel movement?

☐ Daily ☐ Every other day ☐ Less than 3 times a week ☐ Other: \_\_\_\_\_

5. What is your blood pressure status?

☐ Normal ☐ Elevated ☐ Low ☐ Not sure

If known, please provide the most recent reading: \_\_\_\_\_

6. How would you rate your sleep quality?

☐ Excellent ☐ Good ☐ Fair ☐ Poor Average hours of sleep per night: \_\_\_\_\_ Any specific sleep issues? (e.g., trouble falling asleep, waking up frequently):

7. How would you rate your current mood?

☐ Excellent ☐ Good ☐ Fair ☐ Poor Do you currently experience any of the following? ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Other: \_\_\_\_\_

### **Additional Information**

8. Are you pregnant, breastfeeding, or trying to conceive? ☐ Yes ☐ No ☐ N/A

9. Do you consume alcohol, caffeine, tobacco, or recreational drugs?

☐ Alcohol: Amount per week \_\_\_\_\_ ☐ Caffeine: Amount/type per day \_\_\_\_\_

☐ Tobacco: Amount per day \_\_\_\_\_ ☐ Recreational Drugs: Type/frequency \_\_\_\_\_

### **Other Considerations**

10. Is there anything else you feel I should know to ensure a safe and effective herbal recommendation?

*This form is intended to cover the essentials for Rookery Herbal to provide safe and effective herbal remedies without a full case consultation, it is confidential and used for the specific purpose of providing herbs immediately.*

**Waiver and Consent**

I understand that Sarah Richards is a qualified herbal practitioner, not a licensed medical doctor, and does not diagnose, treat, or prescribe for any medical conditions. The advice and information provided are intended to support my overall health and wellness, but are not a substitute for professional medical advice, diagnosis, or treatment.

I understand that it is my responsibility to consult my primary healthcare provider or medical team before starting any new treatments, including herbal products or supplements, particularly if I am currently taking prescription medications or have any existing medical conditions.

By signing below, I acknowledge that I have read, understood, and agreed to the terms outlined above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_