🌿 **Ozigbo's Herbal Healing**

Holistic Herbal & Family Wellness Intake Form

CLIENT INFORMATION

Full Name: _____

Date of Birth: _____ Age: _____

Phone: _____ Email: _____

Address: _____

Emergency Contact Name & Phone: _____

Primary Care Physician (if applicable): _____

Are you pregnant or breastfeeding?

☐ Yes ☐ No

Are you on Thyroid medication?

☐ Yes ☐ No

Blood Thinners?

☐ Yes ☐ No

1. Primary Health Concerns

What are your top wellness concerns? (Check all that apply)

☐ Fatigue / Low energy
☐ Digestive issues
☐ Bloating or gas
☐ Weight gain
☐ Difficulty losing weight
☐ Hormone imbalance
☐ Skin issues (acne, eczema)
☐ Brain fog
☐ Stress or anxiety
☐ Sleep problems
☐ Hair thinning or hair loss
☐ Frequent illness
☐ Joint pain or inflammation

🌿 WELLNESS GOALS

1. What is your primary reason for scheduling this consultation?

_____

_____

2. Digestive Health

Do you experience any of the following?

☐ Bloating after meals
☐ Acid reflux
☐ Constipation
☐ Diarrhea
☐ Food sensitivities
☐ Stomach pain
☐ Parasite concerns

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3. Energy & Stress

How often do you experience:

Low energy
☐ Rarely
☐ Sometimes
☐ Often

High stress levels
☐ Rarely
☐ Sometimes
☐ Often

Poor sleep quality
☐ Rarely
☐ Sometimes
☐ Often

4. 🌿 LIFESTYLE ASSESSMENT

Average hours of sleep per night: _____

Water intake per day: _____

Exercise frequency:
☐ None
☐ 1–2x per week
☐ 3–4x per week
☐ 5+ per week

Stress level (1–10): _____

Describe your typical daily diet:

Bowel movements:
☐ Daily
☐ Every other day
☐ Infrequent
☐ Loose
☐ Difficult

5. Detox & Environmental Exposure

Have you experienced any of the following?

☐ Exposure to heavy metals
☐ Mold exposure
☐ Frequent headaches
☐ Chemical sensitivity
☐ Chronic fatigue

6. Current Supplements or Herbs

Please list any supplements or herbal products you currently take:

🌿 MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

☐ High blood pressure
☐ Diabetes
☐ Thyroid disorders
☐ Anemia
☐ Autoimmune condition
☐ Heart disease

☐ Anxiety/Depression
☐ Hormonal imbalance
☐ Digestive disorder

☐ Cancer

☐ Other: _____

Any Surgeries or major health issues in the past: _____

Are you currently taking any medications?

If yes, list: _____

_____

_____

7. Do you have any allergies (food, herbs, medications)?

If yes, list: _____

_____

🌿 CONSENT & DISCLAIMER

I understand that the services provided by Ozigbo's Herbal Healing are for educational and wellness support purposes only. These services are not intended to diagnose, treat, cure, or prevent any disease. I acknowledge that I should consult with my licensed healthcare provider regarding any medical condition or medication changes.

I understand that herbal and nutritional recommendations are not a substitute for medical care.

Client Signature: _____
Date: _____