

 **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): _____

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
-

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. Hormone Health (Optional)

- PMS symptoms
- Irregular cycles
- Menopause symptoms
- Mood swings
- Low libido
- Unexplained weight gain

5 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

6. Detox & Environmental Exposure

Have you experienced any of the following?

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

7. 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: _____

Surgeries (if any):

8. Health Goals

What are your primary wellness goals?

- Detoxification
 - Hormone balance
 - Gut health improvement
 - Increased energy
 - Weight balance
 - Stress reduction
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9. Interest in Wellness Testing

Are you interested in functional wellness testing to identify root causes of health concerns?

- Yes
 - No
 - Maybe / Need more information
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 **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: _____

