Herbal Health Consultation

Thank you for taking the time to fill out this form. Please feel free to put question marks next to any sections that you have questions about, and answer only those you are comfortable answering.
During the consultation we will go over this form together.

This questionnaire asks you to assess how you have been feeling **over the last 4 months**.
This information will help to keep track of how your physical, emotional and mental states change as you adjust your eating habits, lifestyle choices, priorities, supplement program, exercise, stress management, and personal growth.

INTAKE

Name___________________________________ Today's Date ________________________

Address____

____

Phone # Home__________________ Cell __________________email______________________

Birth Date __________________________ Gender__________

Occupation____

Passions/Interests____

Who do you share your home with_______________________________________

What type of practitioners are you currently under the care of?

____

Would you like any of the above practitioners to be notified of our work together?________________________

What would you like help with at this time?

____

____

____

____

____

____

____

Date of last physical exam________________________

Outcome____

____

____

____

____

What type of therapies have you tried for your current concern(s)?

Diet Modification Vitamin/Mineral Supplementation Herbal Therapy Homeopathy Chiropractic

Acupuncture Conventional Drugs Other (please specify)____

Are you still using these therapies? ____

Details of Above (use back if you need more space)

____

____

____

List current health problems for which you are being treated

____

____

____

Major hospitalizations, illnesses, injuries:

Year Specifics Outcome

____

____

____

____

Do you know your current blood pressure? ____________ Date last taken? ___________________

Do you have any allergies? Yes / No If so, what are they? ____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (change in job, work, residence, finances, etc)

____

____

Is your job associated with exposure to potentially harmful chemicals or health and/or life threatening activities? Explain

____

____

Do you consider yourself Underweight Overweight Just right Your weight today _________________

Unintentional weight loss or gain of 10 pounds or more in the last 3 months

Do you have regular bowel movements? Yes / No

How many bowel movements do you have per day? ____________ How many per week? _______________

Is it ever difficult? ____

How is your digestion? ____

LIFESTYLE

Please circle or fill in the appropriate response.

Your honest answers will greatly help the evaluation process.

Do you….

Exercise adequately? Yes / No How many minutes total per week? ________________

What exercise do you do? ____

Sleep well? ______________________________________ How many hours per night? _________ Do you nap? Yes / No

Like your work? Yes / No How many hours per week do you work? _________________

Are you satisfied with your energy levels? Yes Sometimes No

What would you describe as the two main emotions in your life at this time?

____

Do you use any of the following on a regular basis (circle) ?

Laxatives Coffee Tobacco Marijuana Aspirin Advil/Tylenol/Aleve etc. Alcohol

List any prescription or non-prescription pharmaceuticals that you take on a regular basis, with amounts and how long you have been taking them. Feel free to use the back of the sheet if necessary.

____

____

____

____

List any herbs or supplements you take now or have taken. Include dates and amounts. **Please remember to bring the bottles with you**. Feel free to use the back of the sheet if necessary.

____

____

____

____

Are you allergic, or have side effects to, any herbs, supplements, or pharmaceuticals?

____

____

____

What are your favorite foods and herbs/spices?

____

____

What foods and herbs do you not like?

____

____

____

MEDICAL HISTORY

Arthritis
Alcoholism
Allergies
Anger, excessive
Asthma
Autoimmune Disease
Bloating
Blood Pressure Problems
Bronchitis
Bruise easily
Cancer
Chronic Fatigue Syndrome
Carpal Tunnel Syndrome
Cholesterol, elevated
Constipation
Circulatory Problems
Depression, anxiety
Diabetes / hypoglycemia
Diarrhea
Diverticulitis
Drug abuse
Eczema/Psoriasis
Eyes, ears, nose, throat problems
Environmental sensitivities
Fibromyalgia
Food intolerance
Gas
Gout
Heartburn
Heart Disease
Infection, chronic
Inflammatory bowel disease
Insomnia
Irritable bowel syndrome
Kidney or bladder disorders
Liver or gallbladder disorders
Memory loss
Migraine headaches
Nausea
Night sweats
Numbness/Tingling
Sinus problems
Stroke
Tendonitis
Thyroid disorders: High / Low
Obesity
Osteoporosis
Pneumonia
Skin problems
Ulcer
Urinary tract infection
Varicose veins/hemorrhoids
Water retention/Edema
Other______________________________
____

MEN/AMAB
Prostate enlargement
Prostate cancer
Prostate pain
Burning on ejaculation
Impotence
Blood in urine
Difficulty urinating
Dribbling stream of urine
Decreased sex drive
Infertility
Other______________________________
____
____

WOMEN/AFAB
Menstrual irregularities
Endometriosis
Infertility
Fibrocystic breasts
Fibroids/ovarian cysts
PMS
Breast cancer
Breast Pain
Pelvic Inflammatory Disease
Vaginal infections
Decreased sex drive
Pregnant at this time
Age of first period_______
Date of last Gyn exam_________
Mammogram + –
Latest PAP Results?_____________
Form of birth control________________
# of pregnancies__________
Surgical menopause
Menopause
1st day of last menstrual cycle__________
Length of cycle _______ days
Any recent changes in menstrual flow?
Describe____________________________
____
____

NUTRITION & DIET
Mixed food (animal/vegetable)
Vegetarian
Vegan
Salt restriction
Fat restriction
Carb restriction
Calorie restriction
Specific food restrictions (e.g., dairy, soy, wheat, gluten, eggs)
Describe____________________________
____
____
Other______________________________
____
____
____

FOOD FREQUENCY
Servings per day:
Fruit __________
Dark green or yellow/orange vegetables
____
Grains, unprocessed ________
Beans, peas, legumes _______
Nuts/seeds, raw _________
Dairy, eggs __________
Meat, poultry, fish _________
Candies, cookies __________

EATING HABITS
Skip breakfast
Two meals/day
One meal/day
Graze (small, frequent meals)
Food rotation
Eat constantly, whether hungry or not
Eat on the run
Add salt to food
What foods do you crave?
____
____

FAMILY HISTORY
Has anyone in your family had any of the following? If so, please specify your relationship to them:

Cancer
Diabetes
Allergies/Asthma
Alcoholism
Heart Disease
High/ Low blood pressure
Depression
Arthritis
Stroke