HERB DOC CONSULTING SERVICES

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HEALTH HISTORY

General Information

NAME: _____ SEX: *MALE* ☐ *FEMALE* ☐ DATE: _____

ADDRESS: _____ PHONE: _____

CITY, STATE: _____ ZIP CODE: _____ DOB: _____

MARITAL STATUS: _____ CHILDREN/DEPENDENTS: _____

NEAREST RELATIVE (*NAME/PHONE/ADDRESS*): _____

_____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

HOBBIES, SPECIAL INTERESTS: _____

_____

PHILOSOPHICAL OR RELGIOUS AFFILIATION (*OPTIONAL*): _____

HOW DID YOU HEAR ABOUT US? _____

MEDICAL DOCTOR OR OTHER PRACTICIONERS: _____

LIST ANY MEDICATIONS OR THERAPIES YOU ARE CURRENTLY TAKING OR UNDERGOING: _____

_____

_____

HAVE YOU EVER HAD ACUPUNCTURE TREATMENTS? _____

WITH WHOM AND APPROXIMATELY HOW MANY? _____

HAVE YOU EVER UNDERGONE HERBAL THERAPY BEFORE? _____

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Main Health Issue

PRIMARY COMPLAINT (*DESCRIBE YOUR SYMPTOMS TO THE BEST OF YOUR ABILITY*): _____

ACCOMPANYING SYMPTOMS: _____

HOW HAVE YOU BEEN TREATED BY ANYONE ELSE FOR THIS CONDITION? _____

APPROXIMATELY WHEN DID YOU FIRST NOTICE IT: _____

HOW LONG HAS IT BEEN OCCURING? _____

WHEN & UNDER WHAT CIRCUMSTANCES IS IT WORSE? _____

WHEN & UNDER WHAT CIRCUMSTANCES DOES IT IMPROVE? _____

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Medical History

MEDICAL HISTORY (*PAST DISEASES*): _____

_____

_____

_____

_____

DO YOU HAVE HIGH BLOOD PRESSURE OR ANY HEART PROBLEMS? _____

OPERATIONS: _____

INJURIES: _____

IF FEMALE, ANY PROBLEMS WITH YOUR MENTRUAL CYCLE (*PLEASE DESCRIBE*): _____

_____

LIST THE DATES/YEARS OF ANY CHILDREN YOU BIRTHED AND WHETHER THE DELIVERY WAS NORMAL:

_____

_____

_____

HOW IS YOUR ENERGY LEVEL? _____ SEX DRIVE? _____

APPETITE AND DIGESTIVE PROBLEMS: _____

ANY PROBLEM WITH YOUR GLANDS OR VITAL ORGANS? _____

ARE YOUR BOWELS REGULAR (*DAILY*)? _____ CONSISTENCY/COLOR: _____

URINARY FREQUENCY MORE THAN 6X DAILY OR LESS THAN 4? _____

ANYTHING UNUSUAL ABOUT THE COLOR OF YOUR URINE? _____

NIGHTIME URINATION: _____

ANY RECURRING DREAMS: _____

_____

_____

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Medical History Continued

DO YOU HAVE A STRONG PREFERENCE OR AVERSION TOWARDS ANY FOODS/DRINKS? _____

_____

DO YOU USE ALCOHOL, MARIJUANA, COFFEE, COCAINE, ANY RECREATIONAL DRUGS? _____

_____

SUGAR ADDICTION? _____

DO YOU HAVE AN UNUSUAL SUSCEPTIBILITY TO HOT OR COLD? _____

WHICH IN TERMS OF CLIMATE, FOOD, AND TEMPERATURE DO YOU CRAVE OR PREFER? _____

_____

WHAT SORT OF PHYSICAL ACTIVITIES AND/OR EXERCISE DO YOU REGULARLY ENGAGE IN? _____

_____

HOW IS YOUR SLEEP? _____

HOW ARE YOUR MOODS OR EMOTIONS? DO YOU RECOGNIZE ANYTHING THAT YOU MAY NEED TO FOCUS ON OR ADDRESS IN TERMS OF YOUR MENTAL STATE (*RELATIONSHIPS TO FAMILY, FRIENDS, JOB, ETC.*)?

_____

_____

_____

HOW IS YOUR MEMORY? _____

DO YOU GENERALLLY RESPOND WELL TO MEDICAL TREATMENT, MEDICINES, THERAPIES, ETC? _____

ANY SPECIAL AMBITIONS OR DESIRE THAT COULD HAVE SOME RELATIONSHIP TO YOUR HEALTH? _____

_____

_____

ANY PARTICULAR DIET OR NUTRITIONAL PROGRAM YOU FOLLOW (*VEGETARIAN, REGULARY EAT MEAT, ETC*):

_____

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Medical History Continued

DO YOU SOMEWHAT REGULARY EAT BROWN RICE AND OTHER WHOLE GRAINS? _____

WHERE DO YOU GENERALLY SHOP FOR FOOD? _____

DO YOU GENERALLY COOK YOUR OWN FOOD? _____

PARENTS' HEALTH AND THE HEALTH OF CLOSE RELATIVES: _____

_____

_____

_____

_____

_____

_____

Dietary Questionnaire

Please place a check mark on the appropriate line of frequency and fill in blanks where applicable.

FRUIT (List below the ones you eat most often)	*DAILY*	*OCCASIONALLY*	*SELDOM*

Approximate PERCENT of the total fruit you eat: *Raw*_____ *Cooked*_____ *Juiced*_____ *Dried*_____

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Dietary Questionnaire Continued

Please place a check mark on the appropriate line of frequency and fill in blanks where applicable.

VEGETABLES (List the ones you eat most often)	*DAILY*	*OCCASIONALLY*	*SELDOM*

Approximate PERCENT of the total vegetables you eat: *Raw*_____ *Cooked*_____

WHOLE GRAINS / LEGUMES	*DAILY*	*OCCASIONALLY*	*SELDOM*
Breads			
Pasta			
Crackers			
Whole Grains, *list:* _____			
_____			
Dried Beans, *list:* _____			
_____			

NUTS / SEEDS	*DAILY*	*OCCASIONALLY*	*SELDOM*
Peanuts			
Peanut Butter			
Walnuts			
Almonds			
Cashews			
Pecans			
Sunflower Seeds			
Pumpkin Seeds			
Other: _____			

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Dietary Questionnaire Continued

Please place a check mark on the appropriate line of frequency and fill in blanks where applicable.

ANIMAL PRODUCTS	*DAILY*	*OCCASIONALLY*	*SELDOM*
Beef			
Pork			
Poultry			
Chicken			
Turkey			
Cornish Hen			
Other: _____			
Fish, *type*: _____			
Eggs			
Other: _____			

DAIRY	*DAILY*	*OCCASIONALLY*	*SELDOM*
Milk			
Cheese			
Yogurt			
Ice Cream			
Cottage Cheese			
Butter			

SWEETS	*DAILY*	*OCCASIONALLY*	*SELDOM*
Sweet Rolls / Donuts			
Candy			
Pies / Cakes			
Cookies / Brownies			
Other: _____			

SALTY SNACKS	*DAILY*	*OCCASIONALLY*	*SELDOM*
Potato Chips			
Corn / Tortilla Chips			
Snack Mixes			
Popcorn			
Other: _____			

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Dietary Questionnaire Continued

Please place a check mark on the appropriate line of frequency and fill in blanks where applicable.

FLUIDS	*DAILY*	*OCCASIONALLY*	*SELDOM*
Water, *type*: _____			
Juice, *types*: _____			
Soda Pop			
Kool-Aid			
Sports Drinks			
Coffee			
Tea (Hot or Iced)			

HABITS / PREFERENCES	*DAILY*	*OCCASIONALLY*	*SELDOM*
Do you eat fast food?			
How often do you eat out?			
	YES	*NO*	*SELDOM*
Prefer candy?			
Prefer cookies?			
Love chocolate?			
Love coffee?			
Become overactive for two hours after eating sweets?			
Have headaches, stomach aches, periodic attacks of vomiting?			
Have temper outbursts, good and bad days or Jekyll-Hyde behavior?			
Become withdrawn, daydream or seem far away?			
Have picky and finicky eating habits?			

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Review of Symptoms and their History

Please indicate with a check mark any problems that you have or occasionally have had in recent years. Mark with two checks if the problem occurs often, and use three checks if the condition is of major concern. For chronic or recurrent problems, indicate the year when the problem first arose (for instance, 1979).

WATER ELEMENT IMBALANCE

_____ Fatigue
_____ Heart palpitations
_____ Hearing loss
_____ Ringing in ears
_____ Ear infections
_____ Shoulder / neck tension
_____ Lower back ache
_____ Sinus congestion
_____ Sciatica / nerve pain
_____ Arthralgia (joint pain)
_____ Muscle spasms
_____ Admominal bloating
_____ General edema
_____ Darkness under eyes
_____ Headaches
_____ Dizziness
_____ Emotional instability
_____ Aversion to cold
_____ Hair thinning or loss
_____ Premature aging
_____ Frequency of urination
_____ Night sweats
_____ Insomnia
_____ Change in sexual energy
_____ Bladder infections
_____ Kidney stones
_____ Cold feet
_____ Cold hands
_____ Lack of perspiration
_____ Weakness of legs / knees
_____ Asthmatic cough
_____ Rapid weight change

WOOD ELEMENT IMBLANCE

_____ Migraines
_____ Poor eyesight
_____ Eye infections
_____ Glaucoma
_____ Dry eyes
_____ Skin eruptions
_____ Eczema
_____ Shingles
_____ Rashes
_____ Warts
_____ Nervousness
_____ Twitching
_____ Convulsions
_____ Irritability
_____ Constipation
_____ Hemorrhoids

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Symptoms and their History Continued

Please indicate with a check mark any problems that you have or occasionally have had in recent years. Mark with two checks if the problem occurs often, and use three checks if the condition is of major concern. For chronic or recurrent problems, indicate the year when the problem first arose (for instance, 1979).

WOOD ELEMENT IMBALANCE CONT.

_____ Jaundice
_____ Hepatitis
_____ Herpes simplex
_____ Ulcer
_____ Vomiting
_____ Chest discomfort
_____ Loss of appetite
_____ Tendonitis
_____ Menstrual irregularity

EARTH ELEMENT IMBALANCE

_____ Indigestion
_____ Flatulence
_____ Food allergy
_____ Stomachache / ulcer
_____ Diarrhea
_____ Anemia
_____ Weakness
_____ Haliotosis
_____ Sores in mouth
_____ Heartburn
_____ Nausea / appetite loss

FIRE ELEMENT IMBALANCE

_____ Dry scalp
_____ Acne
_____ Sore throat / tonsillitis
_____ Lymphatic swelling
_____ Feverish feeling
_____ Aversion to heat
_____ Bitter taste in mouth
_____ Gum problems
_____ Nosebleed
_____ Sores in mouth
_____ Facial redness
_____ Itching, burning skin
_____ Hot hands and fee
_____ Excess uterine bleeding
_____ Smoker's cough

METAL ELEMENT IMBLANCE

_____ Bronchitis / asthma
_____ Hay fever
_____ Shallow breathing
_____ Cough
_____ Sinus congestion
_____ Dry skin
_____ Constipation
_____ Nasal infections

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Symptoms and their History Continued, ***Female Clients Only***

Please indicate with a check mark any problems that you have or occasionally have had in recent years. Mark with two checks if the problem occurs often, and use three checks if the condition is of major concern. For chronic or recurrent problems, indicate the year when the problem first arose (for instance, 1979).

_____	Vaginal infection with discharge	_____	Urinary infection
_____	Yeast infection	_____	Infertility
_____	Ovarian cyst	_____	Pelvic inflammatory disease
_____	Endometriosis	_____	Genital burning
_____	Menstrual cramping	_____	Positive PAP test
_____	Breast lumps	_____	Excess bleeding
_____	Herpes	_____	Irregular periods
_____	Hemorrhoids	_____	Pre-menstrual syndrome
_____	Anal fissures		

Please provide any additional information about you and your condition that might not have been covered by the above questions.

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