Health History Intake Form

Date:_____

Please complete this health history questionnaire. Please specify if you are okay with the information being shared with The Joy Centers Team of practitioners. If otherwise, all information will be kept strictly confidential with Amethyst Pishue.

☐ I, _____ give consent for the following information to be shared with The Joy Centers team of practitioners understanding that it will be used to curate a plan of care on my behalf.

☐ I would like that the following information be kept confidential with Amethyst Pishue at this time.

*I am not an MD or ND. I do not have the years of medical schooling that it takes to safely and properly give a diagnosis, and although I am currently certified in Natural Holistic Remedies and have completed a full year at Cedar Mountain Herb School as well as years of additional courses and classes, anything I suggest is in no way a cure, I cannot predict how a remedy will work for you, everybody is different. Always refer to your medical care provider for questions about your health. I have a team of practitioners that will be overseeing as well as giving input on care following this intake form (If give consent). Please include your full name above stating that you agree to release the following information to whom; The Joy Centers and/or Amethyst Pishue.

*The information I provide is not intended to be a substitute for medical treatment but instead to help support or bolster what concerns arise. Please consult your medical care provider before using herbal medicine, particularly if you have a known medical condition or if you are pregnant or nursing. You are responsible for your own health. As with conventional medicine, herbal medicine is vast and complex, and must be used responsibly. People react differently to different remedies. Some herbs are contraindicated with certain pharmaceutical drugs.

Name:**_____Age:**____***Weight**: _____***Height**:_____

***Chief Complaint or Concern**: _____

_____

_____

History of Present Illness:

1. Location of illness or complaint(s):

2. Severity/Quantity:

3. Duration (how long have you been experiencing this illness or complaint(s):

4. Associated Symptoms:

5. Modifying Factors – what makes it better or worse?

Past Medical History

Have you ever been diagnosed with any of the conditions listed here? If so, who made the diagnosis? When?

Circle and or describe any treatments for the following:

Cancer-

Diabetes-

High Blood Pressure-

Hepatitis-

Thyroid disease-

Seizures-

Other (please list):

Surgeries (including cosmetic & dental)? If you currently have mercury based fillings, previously had a root canal(s), or posts?

Hospitalizations Provide date and reason for each

*__Allergies__: (drugs/chemicals/foods) How were they diagnosed and/or treated?

Major trauma (concussion, accidents, physical or emotional trauma)? Provide type and date for each.

List of all **medications** you have used in the past 6 months. Be sure to include prescription drugs, over-the-counter medications you have purchased yourself, herbs, vitamins and supplements. *(For contraindication reasoning please indicate the reason you took each, who recommended them, dosage and how long you used each one.) _____

_____

_____

_____

Family Medical History:

Has anyone in your immediate, biological family (parents, grandparents, siblings or children) ever been diagnosed with any of these conditions? Please circle and state which family member.

Cancer/Type	Mental Health Issues
Diabetes	Seizures
Heart disease	Alcoholism
High Blood Pressure	Hepatitis
Thyroid Disease	Other (please list)

Occupation:

How long have you had this occupation?

Describe your job/work:

How many hours per day?_____ Hours worked per week? _____

Does your work involve travel? If so, please describe:

What are physical demands of your work (standing, sitting, computer use, etc.)

Do you enjoy your work?

How many hours a day are you in front of a computer/tablet/smart phone?

How would you rate your stress level right now? (Low, Medium, High; indicate contributing factors that may be helpful information)

Physical Activity How many hours of exercise a week?_____ Type of Exercise:

Do you spend time outdoors?

Sleep Habits

Hours of sleep each night:_____ Does your sleep schedule vary?

Do you have insomnia? Do you use sleep medications? How often?

Trouble falling or staying asleep? Do you have sleep apnea?

General Habits

Cigarettes: Do you currently smoke/vape? How many cigarettes per day? If you smoked in the past, how many years did you smoke? When did you quit?

Coffee: How many cups per day? Tea: What kind? How much per day?

Soda: What kind? How many sodas per day?

Alcohol: How much alcohol do you drink each day? Each week? Each month?

What kind of alcoholic beverages do you imbibe?

Has your drinking ever caused problems in your life such as family issues, job loss, legal problems?

Recreational drugs: Are you currently using any kind of recreational drug?

What kind and how often?

Have you used them in the past?

Are you self-medicating? If so, with what?

*Do you take prescription medications for depression, anxiety or other psychological symptoms?

Other Information:

Diet:

*On a separate piece of paper, please provide a rough estimate of the quantity of food eaten in a day:

How long has this been your normal diet?

If it has changed recently, what was it before?

How soon after you wake up do you eat or drink?

Do you crave sugar? What kind of sweets do you enjoy?

Do you crave salt? What kind of salty foods do you enjoy?

How long have been at your current weight?

Any significant weight gain/loss in the past five years?

Have you ever been treated for an eating disorder?

Is your appetite good or poor?

Do you crave specific foods?

If so, which ones?

How much water do you drink each day? Do you keep track of your water intake?

Health History

Please note any health issue that you have had in the past or are currently experiencing, along with a description of any treatments used for each symptom checked/circled.

Skin

Rashes (where?)

Acne

Ulcerations

Excessively oily skin

Hives

Excessively dry skin

Itching

Hair loss

Eczema

Dandruff

Psoriasis

Other

Treatments:

Eyes, Nose, Throat

Glasses or contacts

Frequent ear infections

Glaucoma

Hearing loss

Cataracts

Hay fever

Night blindness

Migraine or other chronic headaches:

Hearing aids

TMJ

Ringing in ears

Chronic dental problems (cavity/root canal/etc)

Sinus problems (chronic congestion/infections)

Mouth ulcers/Oral herpes

Excessive/insufficient saliva

Gum disease

Treatments:

Cardiovasculara

High or low blood pressure

Arrhythmia (irregular heart rate)

Elevated cholesterol or triglyceride levels

Swelling in hands or feet

Poor circulation

Chest pain

Heart disease

Numbness (where?)

Heart palpitations

Pacemaker

Treatments:

Respiratory

Chronic cough

Bronchitis (frequency/treatment)

Frequent colds/respiratory infections

Pneumonia (frequency/treatment)

Asthma (onset/treatment)

Number of colds per year

Difficulty breathing

Number of sinus infections per year

Breathless with exertion

Lung disease (describe)

Treatments:

Other

Treatments:

Gastrointestinal

Nausea

Gastric reflux

Gas

Heartburn

Belching

Urinary Tract

Bladder infections (current or in the past)

Wake up in the night to urinate

Cystitis

Blood in urine

Kidney infections

Kidney stones

Incontinence

Family history of kidney disease

Frequent urination

Irritable Bowel Syndrome

Indigestion

Diverticulitis

Bad breath (halitosis)

Crohn's disease

Bloating after meals

Gastric bypass or similar procedures

Blood in stool

Chronic or frequent constipation or diarrhea
Hemorrhoids

Undigested food in stool

Pain or discomfort with bowel movements

Number of bowel movements per day

Treatments:

Musculoskeletal

Chronic neck or back pain

Osteoporosis

Back surgery

Frequent sprains/torn ligaments

Neck or shoulder tightness

Osteopenia

Osteoarthritis

Other

Low back pain

Treatments:

Rheumatoid arthritis

Neuropsychological

Depression

Experiencing high stress levels

Frequently feel overwhelmed

Poor memory

Anxiety and/or Panic attacks

Ever considered or attempted suicide

Difficulty concentrating

Treated for depression or other psychological issues

Lose your temper easily

Treated for alcohol or drug addiction

Other

Treatments:

Men: Reproductive Health

Prostate inflammation or swelling

Pain or difficulty urinating

Prostate cancer

Venereal disease

Infertility issues

Frequent marijuana user

Benign prostate hypertrophy

Impotence or erectile problems

If you are over 50 years of age: Do you have annual PSA screening? Last screening:

Women: General Reproductive Health

Age of first menses

Breakthrough bleeding

Cycle of menstrual period/days

Fibroids/type?

Length of period

Ovarian cysts/PCOD

PMS symptoms (please check all that apply)

Pelvic inflammatory disease

Edema (swelling of hands or feet)

Sexually transmitted disease/type?

Food cravings

Herpes

Mood swings

Vaginal warts

Insomnia

Cervical dysplasia

Headaches

Irregular PAP test/when?

Cramping

Uterine cancer

Other

Treatments:

Pregnancy

Have you ever been pregnant?

Bloating

Ovarian cancer

Breast tenderness

Breast lumps/cysts

Heavy menstrual flow/Blood clots

Breast augmentation/reduction

Irregular menstrual cycle

Breast cancer

Skipped periods

Breast pain

Pain at ovulation (mid cycle pain)

Currently using birth control

Type of birth control used:

Number of live births

Number of miscarriages

Are you or could you be pregnant now?

Number of abortions

Infertility issues

Health issues during pregnancy?

Date of last PAP:

Date of last mammogram:

Peri-menopausal/Menopausal symptoms
(please check/circle all that apply)

Are you having regular menstrual periods

Date of last menstrual period

Headaches

Hot flashes

Heavy menstrual bleeding/flooding

Night sweats

Incontinence/frequent urination

Insomnia/sleep problems

Memory problems/Poor concentration

Weight gain

Mood swings

Lack of libido

Depression

Vaginal dryness

Fatigue

Currently using hormone replacement therapy? Or using bio-identical hormones

Other: Treatments:

Is there anything else affecting your health right now that you would like me to know about?