HERBAL CONSULT HEALTH INTAKE FORM

Date:

Email:

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 neither an MD or ND. I don't have the years of medical schooling that it takes to safely and properly give a diagnosis, and although I am a MH (Master Herbalist) and certified in Natural Holistic Remedies, anything I suggest is in no way a cure. I cannot predict how a remedy will work for you, every body is so uniquely different. Always refer to your medical care provider for questions about your health. We have a team of practitioners that will be overseeing as well as giving input on care following this intake form (if you agree to that). Please include your full name above stating that you agree to release the following information to whom; The Joy Centers 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. 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?

<u>Past Medical History</u>

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

*Allergic to drugs/chemicals/foods? How were they diagnosed and/or treated?

Major trauma (concussion, accidents, physical or emotional trauma)?

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	
Diabetes	Heart disease
High Blood Pressure	Thyroid Disease
Mental Health Issues	Seizures
Alcoholism	Hepatitis
Other (please list)	Occupation:

How long have you had this occupation?

Describe your job/work:

Do you enjoy your work?

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

How would you rate your stress level right now?

Physical activity

How many hours of exercise a week do you do? Type?

Do you spend time outdoors?

Sleep Habits

Hours of sleep each night:

Have you ever been diagnosed with insomnia?

Trouble falling or staying asleep?

Does your sleep schedule vary?

Do you use sleep medications? How often?

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?

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

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?

Diet

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 you 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?

How much water do you drink each day?

Do you keep track of your water intake?

Health History

Please note any health issues 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
Excessively oily skin	Hives
Excessively dry skin	Itching
Hair loss	Eczema
Dandruff	Psoriasis
Other	Treatments/Products used:

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:

Cardiovascular

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:

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 | Other:

Treatments:

Gastrointestinal

Nausea | Gastric reflux

Gas | Heartburn

Belching | Irritable Bowel Syndrome

Indigestion | Diverticulitis

Bad breath (halitosis) | Crohn's disease

Bloating after meals | Gastric bypass or similar procedures

Chronic or frequent constipation or diarrhea Hemorrhoids

Number of bowel movements per day:

Blood in stool | Undigested food in stool

Pain or discomfort with bowel movements | 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

Cycle of menstrual period/days

Length of period

PMS symptoms (please check all that apply)

Edema (swelling of hands or feet)

Food cravings

Mood swings

Insomnia

Headaches

Cramping

Bloating

Breast tenderness

Heavy menstrual flow/Blood clots

Irregular menstrual cycle

Skipped periods

Pain at ovulation (mid cycle pain)

Breakthrough bleeding

Fibroids/type?

Ovarian cysts/PCOD

Pelvic inflammatory disease

Sexually transmitted disease/type?

Herpes

Vaginal warts

Cervical dysplasia

Irregular PAP test/when?

Uterine cancer

Ovarian cancer

Breast lumps/cysts

Breast augmentation/reduction

Breast cancer

Breast pain

Other:

Treatments:

Pregnancy

Have you ever been pregnant?

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:

Perimenopausal/ Menopausal symptoms (please **check** or **circle** all that apply):

Are you having regular menstrual periods?

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

Date of last menstrual period:

Other:

Treatments:

<u>Musculoskeletal</u>

Chronic neck or back pain

Back surgery

Neck or shoulder tightness

Low back pain

Osteoporosis

Osteopenia

Treatments:

Osteoarthritis

Rheumatoid arthritis

Frequent sprains/torn ligaments

Other

<u>Neuropsychological</u>

Depression

Anxiety and/or Panic attacks

Poor memory

Difficulty concentrating

Lose your temper easily

Other

Frequently feel overwhelmed

Experiencing high stress levels

Ever considered or attempted suicide

Treated for depression or other psychological issues

Treated for alcohol or drug addiction

Treatments:

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