Heidi Berkovitz, BA. Ed

Clinical Herbalist

828-707-6681

Name:_____ Date:_____ Referral Source:_____
Address:_____ Phone:_____ Cell:_____
City/State/Zip:_____ Email:_____
Date of Birth_____ Age_____ Place of Birth_____ Ethnicity _____

Occupation:_____ How long?_____
On a scale of 1 to 10 (high) how stressful is your job? _____
Previous occupation _____ Education (Highest level attained) _____
Marital (Union) status _____ Number of times: Divorced _____ Widowed _____

Primary Physician:_____ Phone:_____
May we consult with your physician? ____yes _____no
Emergency contact:_____ Phone:_____

Most you have weighed as an adult _____ Year _____
Least you have weighed as an adult _____ Year _____
Have you had any vaccinations in the last 10 Years? If so what and when?_____
_____

What concerns would you like to address and how long have they been an issue?

1. _____
2. _____
3. _____

In order to change these conditions, are you willing to make lifestyle modifications?
Yes____ No_____ Maybe_____

What other health related issues have you had in the past?

Year/Condition _____

Year/Condition _____

Year/Condition _____

<u>Family</u>

Relationship	Alive/Deceased	Present health or cause of death
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
Sisters	_____	_____
Children/ages	_____	_____
	_____	_____
	_____	_____

Check illnesses which have occurred in any of your blood relatives:

_Diabetes _Cancer _Bleeding Tendency _Kidney Disease _Tuberculosis _Allergy __Heart Disease

_Stroke _ High Blood Pressure _ Nervous Illness _ Other _____

List the types of foods you eat for:

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Snacks & Times eaten _____

What foods do you crave? _____

What food do you react to? _____

What food do you NOT like? _____

Have you had allergies or sensitivity to medicines or other substances? No ____ Yes ____

List: _____

Do you Use:

	Now	In the Past	Type	Amount/Day	For how long?
Tobacco	____	_____	_____	_____	_____
Alcohol	____	_____	_____	_____	_____
Coffee/Caffeinated Tea	____	_____	_____	_____	_____
Marijuana	____	_____	_____	_____	_____
Recreational Drugs	____	_____	_____	_____	_____

List the type of exercise you get in a typical week.

Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____

Medications currently or previously (in last year) used

Name	Dosage/Frequency	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements/vitamins/herbs currently used

Name	Dosage/Frequency	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any major health conditions: _____
_____

LOWER GI

___ Constipation with gas	___ Stools loose with gas
___ Frequent constipation	__ Digestion unusually rapid
___ Light colored, hard stools	___ Loose stools when tired/stressed
___ Intestines often bloated	___ Dark, soft stools
___ Constipation with hemorrhoids	___ Quick defecation after eating
___ Constipation with painful defecation	___ Constipation w/ fully formed stools
___ Constipation w/ hard, marbly stools	___ Tongue often coated

UPPER GI

___ Sometimes nausea in evenings	___ Sometimes nausea in mornings
___ Mouth frequently too dry	___ Sometimes excess salivation
___ Duodenal ulcer	___ Stomach ulcer
___ Sometimes foul burps	___ Strong, demanding hunger
___ Butterflies in stomach	___ Seldom eat breakfast
___ Often don't finish meals	___ Often eat to calm down
___ Receding gums	___ Frequent use of alcohol
___ Frequent poor appetite	___ Bitter taste in morning
___ "Dragon breath" in morning	___ Acid indigestion at night
___ Frequent mouth cold sores	___ Sometimes difficulty swallowing
___ Indigestion after eating	

LIVER

___ Dry, even scaly skin	___ Moist, sometimes oily skin
___ Hay fever or asthma	___ Hives from food or drugs
___ Craves fruit or sweet	___ Craves proteins, fats
___ Frequent trouble digesting fats	___ Fever with sweat when sick
___ Acne on face AND buttocks	___ Seem to have low blood sugar
___ Had hepatitis in past	___ Frequent use of alcohol
___ Work with solvents	___ Psoriasis, eczema, dermatitis
___ Frequent minor illnesses	___ Don't sweat when sick

RENAL

___ Standing too quickly causes faintness/dizziness	___Wakes up at night to urinate
___ Standing too quickly makes pulse roar in ears	___ Frequent water retention
___ Frequent flushing of blushing	___ Urine usually dark
___ Moderate low blood pressure	___ Moderate high blood pressure
___ Frequent thirst	___ Craving for salt
___Urine always light colored	

LOWER URINARY TRACT

___ Frequent urination, small amounts	___ Infrequent urination, copious
___ Sometimes dribble afterwards	___ Frequent bladder infections
___ Demanding need to urinate	___ Mucus in urine
___ Benign prostatic hypertrophy	___ Dull ache after urination

REPRODUCTIVE

___ Dry skin, cold hands and feet
___ Sweat freely with strong scent
___ Oily skin, facial acne

WOMEN

___ Cycle more than 28 days
___ Cycle less than 28 days
___ Miss some periods
___ Water retention before menses
___ Menses slow starting with cramps
___ Menstruation always lengthy
___ Frequent Class II Pap smear
___ Always hungry before menses
___ History of PID, cervicitis
___ Breasts tender before menses
___ Miscarriages, problem pregnancy
___ Palpitations before menses
___ Period late with altitude change
___ Period early with altitude change
___Hot Flashes
___ Negative reaction to birth control pills
___ Constipation before, loose stools after menses starts

MEN

___ Frequent cannabis user
___ Pain or ache after orgasm
___ Difficulty maintaining erection when in mood
___ Benign prostatic hypertrophy

RESPIRATORY

___ Easy coughing of mucus_
___Yawns frequently
___ Tobacco smoker
___ Sometimes hyperventilates
___ Difficulty swallowing mucus
___ Rapid, shallow breather
___ Shortness of breath when standing or walking
___ Frequent chest colds
___ Sometimes wake up choking or gasping for breath

CARDIO-VASCULAR

___ Fast, light pulse
___ Slow, strong pulse
___ Cold bodied
___ Frequent physical activity
___ Sometimes dizzy or faint
___ Warm bodied
___ Hands cold, clammy or dry
___ Hands warm, sweaty
___ Hypertension, not responding to diuretics
___ Hypertension responds to diuretics
___ Palpitations either as an adolescent or before menses

LYMPHATIC

___ Recuperates slowly if ill	___ Recuperates quickly if ill
___ Injuries heal slowly	___ Injuries heal quickly
___ Eczema, dermatitis	___ Asthma or hay fever
___ Arthritis or rheumatism	

SKIN

___ Skin eruptions are deep, not coming to a head	___ Skin on trunk is dry
___ Skin eruptions are superficial, come to a head	___ Oily scalp or hair
___ Cracks, fissures on heel, elbow, feet, heal poorly	___ Dry scalp or hair

MUCUS

___ Sores, cracks, fissures in mouth, anus, vagina	___ Lips often dry, chapped
___ Food often causes intestinal distress as it passes	___ Gets sore throat easily

GENERAL

Mark all that apply. If mild, mark "1"; if strong, mark "2".

___ Awakens, can't go back to sleep	___ Increase in weight (recent)
___ Bad dreams	___ Lack of sensation somewhere
___ Blurred vision	___ Likes depressants
___ Brown spots, bronzing of skin	___ Likes stimulants
___ Bruises easily	___ Lower back pain
___ Can't gain weight	___ Muscle cramps
___ Can't lose weight	___ Nails split, brittle
___ Can't get started without coffee	___ Nose bleeds frequently
___ Chemical or spray poisoning	___ Pollution heavy in environment
___ Chronic fatigue, depression	___ Ringing in ears
___ Cry easily without apparent cause	___ Pulse speeds up after meals
___ Depressed for long periods	___ Sensitive to cold weather
___ Earaches	___ Sensitive to hot weather
___ Eat often or else faint/nervous	___ Sensitive to high humidity
___ Eyes often red/inflamed	___ Sensitive to low humidity
___ Face, eyes get puffy	___ Sexual desire decreased
___ Facial twitches	___ Sexual desire increased
___ Gum problems	___ Stuffy nose during the day
___ Headaches	___ Stuffy nose in evening/night
___ Headaches in morning, wearing off	__ Tendency to anemia

___ Heart palpitations when hungry
___ Heart palpitation after eating
___ Highly emotional
___ Weight gain in upper arms, shoulders, back of neck
___ Impaired hearing
___ Tremors in hands or neck
___ Varicose veins
___ Highly controlled

Current State of Emotions and Spiritual Wellbeing

Take time to think about the following questions:

Are you completely satisfied with your living conditions? _____
Are you able to express your feelings and emotions? _____
Is there an excess of stress in your life? _____
What is causing the stress? _____
Are you in a healthy relationship? _____
Do you feel well supported? _____
Do you sleep well? _____
Do you dream? _____
Are you satisfied with your energy level? _____
Is it easy to wake up in the morning? _____
Do you enjoy your work? _____
Do you believe in a higher power? _____

Which of these feelings dominate your life? (Circle any that apply)
Joy Happiness Anger Sadness Fear Sympathy Worry Depression
Other?_____

Have you suffered from any stress inducing life events in the last 5 years? (ie: divorce, loss of a lover, loss of a job, change of residence, injury, death of a loved one, etc?)_____
_____
_____
_____
_____

YOUR OPINIONS MATTER:

What do you call your illness? What name does it have? _____

_____

What do you think has caused your illness?_____

_____

Why and when did it start? _____

_____

What do you think the illness does? How does it work? _____

_____

How severe is it? Will it have a short or long course? _____

_____

What kind of treatment(s) do you think you should receive? _____

_____

What are the most important results you hope she receives from this treatment? _____

_____

What are the chief problems the illness has caused? _____

_____

What do you fear most about the illness? _____

_____

ADDITIONAL THINGS YOU WANT TO MENTION:

_____

_____

_____

_____

_____

_____

_____