Assessment Consultation Client Case/Health Record

Date of consultation: _____ Current age: _____
Name: _____ DOB: / / Occupation: _____
Address: _____
Email: _____ Phone #1: _____
Marital status: _____ Children: _____ Possibility of pregnancy now? _____
Doctor (primary): _____ Dr.'s phone: _____
Last seen: _____ Reason: _____ Result: _____
Permission to consult PHCP ☐ yes ☐ _____ *initial here
Client's presenting concern: _____
How long has issue been a problem? _____
How did this problem begin? _____
What aggravates the problem? _____
What, if anything, provides relief? _____
Aim/goal of treatment: _____

_____

Client assessment of severity on scale of 0-10 (0 is none and 10 is intolerable): _____

Exercise: _____ Frequency: _____
_____ _____

Diet assessment: ☐ poor ☐ okay ☐ good ☐ very good ☐ excellent _____
Herbs, vitamins & supplements taken: Name/Dosage/Form

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

☐ chiropractor visits ☐ massage therapy ☐ acupuncture ☐ physiotherapy ☐ other: _____
Recent surgeries? _____ For what reason? _____ When? _____
☐ Cancer: Currently? What type? _____ Previously: When? _____

_____

General health assessment: ☐ good ☐ average ☐ poor
General energy levels: ☐ good ☐ average ☐ poor
General stress levels: ☐ low ☐ average ☐ high
Current Weight/body tone: ☐ healthy ☐ average ☐ poor
General fitness levels: ☐ good ☐ average ☐ poor

Please list traumatic experiences not treated medically (divorce, loss of loved one, loss of job, etc:

_____
_____
_____

Please list chronic conditions (include repeated or sustained injury):

_____
_____
_____

Medical History & Body Analysis

Client Case/Health Record

Current and last 2 years

Skin Conditions

- ☐ Eczmea
- ☐ Psoriasis
- ☐ Pruritis/itchy skin
- ☐ Sun damage/sun spots
- ☐ Rashes/hives
- ☐ Allergic reaction- current
- ☐ Shingles
- ☐ Impetigo
- ☐ Fungal/athlete's foot
- ☐ Warts
- ☐ Moles, skin tags
- ☐ Acne
- ☐ Other: _____
- ☐ Recommend detailed skin form

Cardio/Circulatory

- ☐ Dizziness/vertigo
- ☐ Fainting
- ☐ Nosebleeds
- ☐ Varicose veins
- ☐ Stroke
- ☐ Heart condition
- ☐ Hemorrhoids
- ☐ Cerebral palsy
- ☐ Restless leg syndrome
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Cold hands/feet
- ☐ Alzheimer's disease
- ☐ Other: _____

Respiratory

- ☐ Allergies
- ☐ Asthma
- ☐ Covid 19
- ☐ Bronchitis
- ☐ Strep throat
- ☐ Laryngitis
- ☐ Pneumonia
- ☐ Tonsilitis
- ☐ Cold/flu
- ☐ Cough
- ☐ Sinus infection
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Other:_____

Skeletal

- ☐ Arthritis
- ☐ Back, hip pain
- ☐ Bursitis
- ☐ Gout
- ☐ Headaches
- ☐ Joint stiffness, swelling
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Jaw pain, TMJ
- ☐ Osteoperosis
- ☐ Other: _____

Muscular

- ☐ Muscle spasms
- ☐ Sprains
- ☐ Whiplash
- ☐ Mobility limitations
- ☐ Carpal tunnel
- ☐ Adhesive capsulitis/frozen shoulder
- ☐ Muscle tear
- ☐ Other: _____

Digestive

- ☐ Indigestion
- ☐ Constipation
- ☐ Bloating/gas
- ☐ Diarrhea
- ☐ Gallstones
- ☐ Celiac disease
- ☐ Irritable bowel syndrome
- ☐ Diverticulitis
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Other:_____

Neurological/nervous

- ☐ Dementia
- ☐ Bi polar
- ☐ Parkinson's disease
- ☐ Numbness/tingling
- ☐ Bell's palsy
- ☐ Epilepsy, seizures
- ☐ Stroke
- ☐ Muscular dystrophy
- ☐ Huntington's disease
- ☐ ALS (Amyotrophic Lateral Sclerosis)
- ☐ Other: _____

Immune

- ☐ Cancer
- ☐ AIDS
- ☐ Hay fever/allergies
- ☐ Multiple sclerosis
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Psoriasis
- ☐ Type 1 diabetes
- ☐ Other: _____

Lymphatic

- ☐ Swollen glands
- ☐ Cellulite
- ☐ Tonsilitis
- ☐ Hodgkin's lymphoma
- ☐ Lymphedema
- ☐ Achy, heavy limbs
- ☐ Chronic inflammation
- ☐ Castleman's disease
- ☐ Non-Hodgkin lymphoma
- ☐ Lymphangitis
- ☐ Other: _____

Medical History & Body Analysis Client Case/Health Record

Current and last 2 years

Urinary & Kidney

- ☐ Cystitis
- ☐ Kidney stones
- ☐ Incontinence
- ☐ Bladder infection
- ☐ Diabetic nephropathy
- ☐ Polycystic kidney disease
- ☐ Other: _____

Endocrine

- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hashimoto's disease
- ☐ Cushing disease
- ☐ Adrenal issues
- ☐ Diabetes
- ☐ Acromegaly
- ☐ Grave's disease
- ☐ Prolactinoma
- ☐ Other: _____

Vision & Hearing

- ☐ Glaucoma
- ☐ Vertigo
- ☐ Ear infection
- ☐ Tinnitus
- ☐ Meniere's disease
- ☐ Impaired vision
- ☐ Pneumonia
- ☐ Other:_____

Male Reproductive

- ☐ Cancers (testicular, penile)
- ☐ Enlarged prostate
- ☐ Prostate cancer
- ☐ Andropause
- ☐ Male infertility
- ☐ Hypogonadism (testosterone)
- ☐ Sexually transmitted disease
- ☐ Other: _____

Female Reproductive

- ☐ Breastfeeding problems
- ☐ Post natal depression
- ☐ PMS, painful periods
- ☐ Infertility
- ☐ Miscarriage
- ☐ Fertility concerns
- ☐ Perimenopause/menopause
- ☐ Ectopic pregnancy
- ☐ Cervical Dysplasia
- ☐ Menstrual Disorders
- ☐ Pelvic floor prolapse
- ☐ Interstitial Cystitis

Pregnant: _____yes _____no

- ☐ Fibrocystic breast condition
- ☐ Pelvic inflammatory disease
- ☐ Constipation
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fluid retention
- ☐ Uterine fibroids
- ☐ Gynocologic cancer
- ☐ Sexually transmitted disease
- ☐ Polycystic ovary syndrome
- ☐ Sexual violence
- ☐ Other: _____

Medications currently taking:

Name of medication	Dosage	Reason for medication

Contraindicated herbs:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

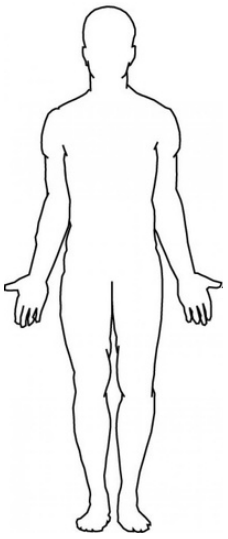
Consultation

Client Case/Health Record

Please check any areas you would like to address:

- ☐ Anxiety
- ☐ Weight loss
- ☐ Muscle strain/pain
- ☐ Immune system
- ☐ Sprains/strains
- ☐ Headache
- ☐ Asthma
- ☐ Depression
- ☐ Cellulite
- ☐ Arthritis
- ☐ Reproductive
- ☐ Sinus
- ☐ PMS/PMT
- ☐ Respiratory
- ☐ Stress
- ☐ Circulation
- ☐ Fibromyalgia
- ☐ Menopausal
- ☐ Nausea
- ☐ Skin care
- ☐ Digestive issues
- ☐ Fatigue
- ☐ Varicose veins
- ☐ Constipation
- ☐ Fungal infection
- ☐ Acne
- ☐ Eczema/psoriasis
- ☐ Memory recall

- ☐ Anger/rage
- ☐ Trauma
- ☐ Concentration
- ☐ Frustration
- ☐ Sadness
- ☐ Shock
- ☐ ADHD
- ☐ Addiction
- ☐ Sleep issues
- ☐ Exhaustion
- ☐ Pessimism
- ☐ Hopelessness
- ☐ Transitioning
- ☐ Confidence
- ☐ Nervous tension
- ☐ Confusion
- ☐ Panic
- ☐ Restlessness
- ☐ Fearfulness
- ☐ Irritability
- ☐ _____
- ☐ Apathy
- ☐ Obsessions
- ☐ Self esteem
- ☐ Grief, heartache
- ☐ Worry
- ☐ Hyperactive
- ☐ _____



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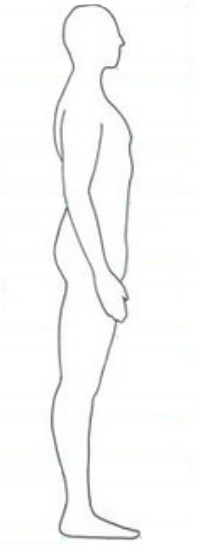

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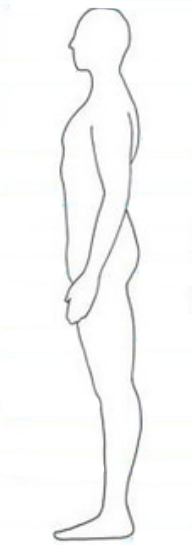

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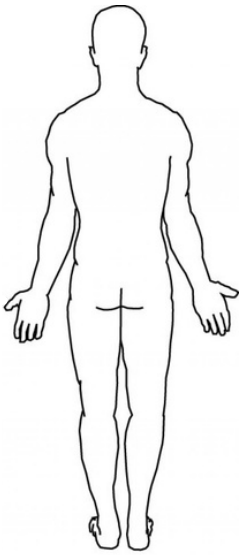

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What applications do you prefer?

- ☐ Tea or infusion
- ☐ Tincture
- ☐ Glycerite
- ☐ Infused honey or syrup
- ☐ Compress
- ☐ Powdered capsule
- ☐ Infused oil
- ☐ Other

Herbs liked or tolerated:

_____

_____

_____

_____

_____

Disliked herbs, allergies:

_____

_____

_____

_____

_____

Timeline