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The following is a confidential questionnaire about your health. Feel free to answer only what feels appropriate. Please email the completed form to the above email address or bring it to your appointment. I look forward to meeting you in person.

Herbal Consultation

Name _____ Date of Birth _____

Height _____ Weight _____ Blood Type _____

Phone _____ Mobile _____

Email _____ Profession _____

Emergency Contact, Phone Number and your relation to this person

_____

With whom do you share your home? (include children and pets)

_____

Health Care Providers and Address: _____

_____

_____

How were you referred to me? _____

Personal Health Profile

Present Health Concerns

What is/are the main health issues(s) that you would like me to address with you? Include primary complaints and symptoms.

_____

_____

_____

_____

What are your long term goals regarding your health?

_____

_____

Please list any medical diagnoses, including mental health, that you have received.

_____

_____

_____

List major accidents, illnesses, hospitalizations and surgeries. Include dates if possible.

_____

_____

List any non-traditional healthcare providers like massage therapists, acupuncturists, etc.

_____

_____

Please list any prescribed and over the counter medications, nutritional supplements, vitamins and herbs you are currently taking. Include dosage, how long you have been taking them and what the medicines are treating.

_____

_____

_____

_____

Have you ever taken western herbs, Chinese herbs or homeopathy in the past? Please describe your experience.

_____

_____

_____

List any allergies to herbs or western medicines.

_____

_____

Describe your exercise practice?

_____

_____

Stress and Sleep

How would you describe your general energy levels?_____

_____

What causes stress for you and how well are you managing your stress currently?

_____

_____

Where do you tend to hold stress in your body? _____

_____

What do you do to relieve stress? _____

_____

In general, how do you view your life currently? (circle one) very stressful, moderately stressful, stressful from time to time, hardly stressful at all.

In general, how is your sleep? How many hours of sleep do you get each night?

_____

How many hours do you need to feel well-rested?

_____

Do you wake up still tired after a full night's sleep? _____

Gastrointestinal History

Describe your typical:

Breakfast:_____

_____

Lunch:_____

_____

Dinner:_____

_____

Snacks:_____

Water Intake(glasses/day) _____ Caffeine_____

What is the worst item in your diet? _____

What foods do you crave? _____

Are you subject to binge eating?_____

If so, what foods?_____

Do you experience bloating/gas/burps after eating? _____

If so, what foods trigger this?_____

Any Known Food Allergies?_____

Describe_____

_____

How often are your bowel movements?_____

Do your stools: sink_____float_____ Constipation? _____

Blood in stool ?_____ Mucus in stool?_____

Pain when stooling?_____ Diarrhea?_____

Other?_____

Emotional & Spiritual

What is your opinion of yourself?

_____

Describe the most positive emotion you experience.

_____

When do you experience this emotion?

_____

Describe the most negative emotion you experience.

_____

When do you experience this emotion?

_____

Describe your Spiritual and/or Religious practice:

_____

On a scale of 1 – 10 (1 being the lesser, 10 the greater)

Please rate yourself in each of these qualities:

Faith_____Hope_____Charity_____Generosity_____

Sense of Humor_____Fear_____Grief_____Sense of Fun_____

Health History

Please check any item below, rating it as follows:

1=sometimes 2=often 3=major concern 4=past issue

Circulatory

_____High Blood Pressure
_____Low Blood Pressure
_____Irregular Heart Beat
_____Pain in Heart Area
_____High Cholesterol
_____Varicose Veins
_____Phlebitis
_____Poor Circulation
_____Previous Heart Attack
_____Previous Stroke
_____Swelling in Joints
_____Anemia
_____Other:

Respiratory, Eyes and Ears

_____Allergies/ Hay Fever
_____Asthma
_____Sinus Congestion
_____Post-Nasal Drip
_____Lung Congestion
_____Difficulty Breathing
_____Sore Throat
_____Cough
_____Recurrent Colds
_____Ear Aches/ Infections
_____Eye Pains
_____Failing Vision
_____Hearing Loss
_____Tonsillitis
_____Teeth, Gum Problems
_____Recurrent Infections
_____Other:

Skin

_____Bruise Easily
_____Dryness
_____Itching
_____Psoriasis
_____Eczema
_____Herpes Simplex
_____Slow Wound Healing
_____Other:

Digestive

_____Mouth Ulcers
_____GERD
_____Hiatial Hernia
_____Bloating
_____History of Hepatitis
_____Gall Stones
_____Hypoglycemia
_____Indigestion
_____Poor Appetite
_____Nausea
_____Ulcers
_____Colitis
_____Constipation
_____Diarrhea
_____IBS
_____Hemorrhoids
_____Gas
_____Belching
_____Digestive Pain
_____Bad Breath

Travel abroad within past 3 years? Where?

_____Other:

Urinary

_____Bladder Infections
_____Kidney Stones
_____Water Retention
_____Incontinence
_____Painful Urination
_____Excessive Urination
_____Gout
_____Other:

Musculo / Skeletal

_____Bursitis
_____Osteoporosis
_____Sprains (where/when)

_____Major Back Pain
_____Broken Bones (which?)

_____Arthritis (where?)

_____Restricted Mobility (where?)

_____Cramps (where?)

_____Scoliosis
_____Disc Problems (describe)

_____Excessive Tension (where?)

_____Other:

Lymphatic

_____Swollen Glands
_____Infection (where?)

_____Other:

Endocrine

_____Hyperthyroid
_____Hypothyroid
_____Pancreas Problems
_____Adrenal Problems
_____Diabetes (Type I or Type II)
_____Hypoglycemia
_____Other:

Immune

_____Auto-immune Disease (describe)

_____Chronic Fatigue Syndrome
_____Fibromyalgia
_____Frequent Colds
_____History of Cancer (Type/When?)

Reproductive Men

_____Benign Prostatic Enlargement
_____Prostatitis
_____STI- Sexually Transmitted Infections (Type/When?)

_____Lack of Sex Drive
_____Impotence
_____Other:

Menstruating Women

Are you trying to get pregnant, or do you think you could be pregnant currently?
Are there any fertility issues you would like to let me know about?

_____Irregular Menstrual Cycles
_____Heavy Menstrual Bleeding
_____Painful Menstrual Cramps
_____Absence of Cycle (How long?)
_____PMS (Describe symptoms)

Other:

Reproductive Women

Have you ever been pregnant?

Please list when.
How many came full term?

Have you ever miscarried? Please list when.

Have you had a hysterectomy?

_____Contraceptives (Type/When?)

_____STI - Sexually Transmitted Infections (Types/When?)

_____Uterine Fibroids
_____Ovarian Cysts
_____Endometriosis
_____Vaginal Infection
_____Breast Pain
_____Fibrocystic Breasts
_____Pelvic Inflammatory Disease
_____Cervical Dysplasia
_____Painful Intercourse
_____Candida
_____Other:

Nervous System

_____Stress
_____Anxiety
_____Irritability
_____Post Traumatic Stress Disorder
_____Headaches (List Types)

_____Insomnia/ Sleep Problems
_____Depression
_____ADHD
_____Hyperactivity
_____Mentally Sluggish
_____Shingles
_____Other:

Menopausal Women

_____Hot Flashes
_____Dry Vaginal Lining
_____Osteoporosis
_____Vaginal Bleeding
_____Estrogen Replacement Therapy
_____Dramatic Mood Swings
_____Other:

Family Health History

Note any immediate family members (parents, grandparents, siblings, aunts or uncles) who have had one or more of the following conditions: Cancer (List Types), Heart Disease, High Cholesterol, Stroke, Diabetes, Mental Illness, Allergies, Asthma and Addiction.

Judith Brooks L.Ac., LMBT NC Licenses: #133, #1313

Notice of Privacy Practice

Understanding your health record: A record is made each time you visit the office. Your current symptoms and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment for future visits. Understanding what information is retained in your record and how that information can be used will help you make informed decisions about your health care.

Understanding your health information rights: You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and to be given an account of those disclosures.

My responsibilities: Judith Brooks L.Ac, LMBT, is required to maintain the privacy of your health information and to provide you with this notice of her privacy practices. Judith Brooks is required to follow the terms of this disclosure and promises to make a good faith effort to notify you of any changes. She agrees not to use or disclose your health information without authorization.

If you believe your privacy rights have been violated, you have the right to file a complaint with Judith Brooks, L.Ac.,LMBT or with the US Secretary of Health and Human Services.

I, _____, have received a notice of this Privacy Practice Disclosure and I realize that my health information is confidential and that any disclosure of my health records is to be authorized by me.

Client Signature:_____ Date:_____

Practitioner Signature:_____ Date:_____