Herbal Health Consultation

With Julie James, Herbalist & Certified Nutritional Consultant

Julie James, Green Wisdom Herbal Healing
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Please take time to read and complete the following:

- Fill out the enclosed intake form. Please only fill out what you are comfortable with.
- Please note any place you have a question and we will be sure to address it. We will go over this form together during the consultation.
- Please bring in a list of any pharmaceutical or over-the-counter medicines that you take on a regular basis with the frequencies, dosages and dates you take them.
- If you are taking any herbal medicines or supplements regularly, **please bring them in the original container they came in so that I can see exactly what you're taking**. Feel free to bring in as well any other supplements that you have, whether you're taking them or not, so that we can possible integrate them into your program.
- You are encouraged to bring along any medical records, blood tests, or other pertinent information you think may be helpful.
- Client confidentiality will be observed under all circumstances.
- Any questions please contact Julie James at the email listed above.

Please understand that Julie James is not a doctor, nor does she take the place of your doctor. She cannot diagnose or prescribe. She is, however, happy to communicate and work with your primary medical provider at your request.

Herbal Health Consultation

Thank you for taking the time to fill out this form. Please feel free to put question marks next to any sections that you have questions about, and answer only those you are comfortable answering.
During the consultation we will go over this form together.

This questionnaire asks you to assess how you have been feeling **over the last 4 months**.
This information will help to keep track of how your physical, emotional and mental states change as you adjust your eating habits, lifestyle choices, priorities, supplement program, exercise, stress management, and personal growth.

INTAKE

Name_____ Today's Date _____

Address_____

_____

Phone # Home_____ Cell _____email_____

Birth Date _____ Gender_____

Occupation_____

Passions/Interests_____

Who do you share your home with_____

What type of practitioners are you currently under the care of?

_____

Would you like any of the above practitioners to be notified of our work together?_____

What would you like help with at this time?

_____

_____

_____

_____

_____

_____

_____

Date of last physical exam_____

Outcome_____

_____

_____

_____

_____

What type of therapies have you tried for your current concern(s)?

☐ Diet Modification ☐ Vitamin/Mineral Supplementation ☐ Herbal Therapy ☐ Homeopathy ☐ Chiropractic

☐ Acupuncture ☐ Conventional Drugs ☐ Other (please specify)_____

Are you still using these therapies? _____

Details of Above (use back if you need more space)

_____

_____

_____

List current health problems for which you are being treated

_____

_____

_____

Major hospitalizations, illnesses, injuries:

Year Specifics Outcome

_____

_____

_____

_____

Do you know your current blood pressure? _____ Date last taken? _____

Do you have any allergies? Yes / No If so, what are they? _____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (change in job, work, residence, finances, etc)

_____

_____

Is your job associated with exposure to potentially harmful chemicals or health and/or life threatening activities? Explain

_____

_____

Do you consider yourself ☐ Underweight ☐ Overweight ☐ Just right Your weight today _____

☐ Unintentional weight loss or gain of 10 pounds or more in the last 3 months

Do you have regular bowel movements? Yes / No

How many bowel movements do you have per day? _____ How many per week? _____

Is it ever difficult? _____

How is your digestion? _____

LIFESTYLE

Please circle or fill in the appropriate response.

Your honest answers will greatly help the evaluation process.

Do you…

Exercise adequately? Yes / No How many minutes total per week? _____

What exercise do you do? _____

Sleep well? _____ How many hours per night? _____ Do you nap? Yes / No

Like your work? Yes / No How many hours per week do you work? _____

Are you satisfied with your energy levels? Yes Sometimes No

What would you describe as the two main emotions in your life at this time?

_____

Do you use any of the following on a regular basis (circle) ?

Laxatives Coffee Tobacco Marijuana Aspirin Advil/Tylenol/Aleve etc. Alcohol

List any prescription or non-prescription pharmaceuticals that you take on a regular basis, with amounts and how long you have been taking them. Feel free to use the back of the sheet if necessary.

_____

_____

_____

_____

List any herbs or supplements you take now or have taken. Include dates and amounts. **Please remember to bring the bottles with you**. Feel free to use the back of the sheet if necessary.

_____

_____

_____

_____

Are you allergic, or have side effects to, any herbs, supplements, or pharmaceuticals?

_____

_____

_____

What are your favorite foods and herbs/spices?

_____

What foods and herbs do you not like?

_____

_____

_____

MEDICAL HISTORY

□ Arthritis
□ Alcoholism
□ Allergies
□ Anger, excessive
□ Asthma
□ Autoimmune Disease
□ Bloating
□ Blood Pressure Problems
□ Bronchitis
□ Bruise easily
□ Cancer
□ Chronic Fatigue Syndrome
□ Carpal Tunnel Syndrome
□ Cholesterol, elevated
□ Constipation
□ Circulatory Problems
□ Depression, anxiety
□ Diabetes / hypoglycemia
□ Diarrhea
□ Diverticulitis
□ Drug abuse
□ Eczema/Psoriasis
□ Eyes, ears, nose, throat problems
□ Environmental sensitivities
□ Fibromyalgia
□ Food intolerance
□ Gas
□ Gout
□ Heartburn
□ Heart Disease
□ Infection, chronic
□ Inflammatory bowel disease
□ Insomnia
□ Irritable bowel syndrome
□ Kidney or bladder disorders
□ Liver or gallbladder disorders
□ Memory loss
□ Migraine headaches
□ Nausea
□ Night sweats
□ Numbness/Tingling
□ Sinus problems
□ Stroke
□ Tendonitis
□ Thyroid disorders: High / Low
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Skin problems
□ Ulcer
□ Urinary tract infection
□ Varicose veins/hemorrhoids
□ Water retention/Edema
Other_____
_____

MEN/AMAB
□ Prostate enlargement
□ Prostate cancer
□ Prostate pain
□ Burning on ejaculation
□ Impotence
□ Blood in urine
□ Difficulty urinating
□ Dribbling stream of urine
□ Decreased sex drive
□ Infertility
Other_____
_____
_____

WOMEN/AFAB
□ Menstrual irregularities
□ Endometriosis
□ Infertility
□ Fibrocystic breasts
□ Fibroids/ovarian cysts
□ PMS
□ Breast cancer
□ Breast Pain
□ Pelvic Inflammatory Disease
□ Vaginal infections
□ Decreased sex drive
□ Pregnant at this time
Age of first period_____
Date of last Gyn exam_____
Mammogram □+ □ –
Latest PAP Results?_____
Form of birth control_____
# of pregnancies_____
□ Surgical menopause
□ Menopause
1st day of last menstrual cycle_____
Length of cycle _____ days
Any recent changes in menstrual flow?
Describe_____
_____
_____

NUTRITION & DIET
□ Mixed food (animal/vegetable)
□ Vegetarian
□ Vegan
□ Salt restriction
□ Fat restriction
□ Carb restriction
□ Calorie restriction
□ Specific food restrictions (e.g., dairy, soy, wheat, gluten, eggs)
Describe_____
_____
_____
Other_____
_____
_____
_____

FOOD FREQUENCY
Servings per day:
Fruit _____
Dark green or yellow/orange vegetables _____
Grains, unprocessed _____
Beans, peas, legumes _____
Nuts/seeds, raw _____
Dairy, eggs _____
Meat, poultry, fish _____
Candies, cookies _____

EATING HABITS
□ Skip breakfast
□ Two meals/day
□ One meal/day
□ Graze (small, frequent meals)
□ Food rotation
□ Eat constantly, whether hungry or not
□ Eat on the run
□ Add salt to food
What foods do you crave?
_____
_____

FAMILY HISTORY

Has anyone in your family had any of the following? If so, please specify your relationship to them:

□ Cancer
□ Diabetes
□ Allergies/Asthma
□ Alcoholism
□ Heart Disease
□ High/ Low blood pressure
□ Depression
□ Arthritis
□ Stroke