



Health History Form



PERSONAL HEALTH PROFILE

"The Earth is a patient healer. One of her important teachings is to be patient".....Wabun Wind

Name:

Date of Birth:

Height:

Weight:

Address

Occupation

What is the **major area** of health concern for you? (Try to narrow it down to 3 or less)?

What is the main area(s) you would like to focus on during this Health & Wellness Program?

What results would you like to accomplish?

How long are you willing and/or able to follow this program?





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PERSONAL HEALTH STATUS

Check each column where symptoms apply and elaborate in space provided below if necessary. Please indicate with an (X) any experiences below that you sometimes experience; two checks (XX) for those which occur often; and use three checks (XXX) for those which are a major concern.

General

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Pain in Heart
- Poor Circulation
- Swelling in Ankles/joint
- Previous heart stroke/murmur

Muscles/Joints

- Backache/upper or lower
- Broken Bones
- Mobility Restriction
- Arthritis/Bursitis
- Congestion

Skin

- Boils
- Bruises
- Dryness
- Itching
- Varicose Veins
- Skin eruptions

Respiratory

- Chest Pain
- Difficulty breathing
- Cough
- Tuberculosis





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Eyes, Ears, Nose, and Throat

- Asthma
- Ear Aches
- Eye Pains, Dry/Wet
- Failing vision
- Hay Fever
- Sinus Infection
- Sinus Congestion
- Sore Throat
- Tonsils
- Hearing Loss

Gastro-Intestinal

- Belching
- Colitis
- Constipation
- Abdominal Pain
- Liver Problems
- Gall Stones
- Ulcers
- Indigestion

Urinary/Kidney

- Excessive Urination
- Water Retention
- Burning Urine
- Kidney Stones
- Lower Back Pain
- Dark circles under eyes





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Itchy Ears/eyes

Emotional Insecurity

Please comment on any of the symptoms checked above that you feel will give a complete overview of your present state of health:

Do you have Allergies? To What?
Are you allergic to any medications? If so, what kind?
Are you allergic to any foods? What kinds?
Do you take any regular medications, either prescribed or-the-counter?
Have you had any operations? What year:
Any major injuries/accidents? What and when:
Any major illness or hospitalizations? What and when:
Do you take regular vitamin, mineral, or herbal supplements? Please list:

Do any of the conditions above aggravate a current health condition?

Please describe your program of physical fitness.

Very active Moderately active Inactive

Any further insights/comment on your level of activity:

COMMON PHYSICAL ACTIVITIES

Please mark those activities you do regularly on a daily basis and approximately how long for each:

Desk Sitting (how long) Standing (how long?___)





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- | | |
|--|---|
| <input type="checkbox"/> Sitting in a car (how Long) | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Jogging/Running | <input type="checkbox"/> Tai Chi |
| <input type="checkbox"/> Calisthenics | <input type="checkbox"/> Hiking |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Bike Riding |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Horseback Riding |
| <input type="checkbox"/> Weight Lifting | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Bending/Lifting |
| <input type="checkbox"/> Other _____ | |

DIETARY HABITS

Please X check each item listed below if it is included in your regular daily diet:

Put XX checks by those you eat most often (more than once a day):

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Red Meat | <input type="checkbox"/> Butter | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Milk | <input type="checkbox"/> Black Tea |
| <input type="checkbox"/> Poultry | <input type="checkbox"/> Cheese | <input type="checkbox"/> Herbal Tea |
| <input type="checkbox"/> Fruits | <input type="checkbox"/> Yogurt | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Vegetables | <input type="checkbox"/> Sugar | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Raw Foods | <input type="checkbox"/> Honey | <input type="checkbox"/> Protein Supplements |
| <input type="checkbox"/> Grains | <input type="checkbox"/> Baked Goods | <input type="checkbox"/> Food Supplements |
| <input type="checkbox"/> Nuts | <input type="checkbox"/> Deserts | <input type="checkbox"/> Smoke Cigarettes |
| <input type="checkbox"/> Seeds | <input type="checkbox"/> Eggs | |
| <input type="checkbox"/> Fermented Foods | <input type="checkbox"/> seaweed | |





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Elaborate on your dietary habits.

- What is it that you like most about your dietary habits:
- What would you would like to change:
- Is there anything that you eat/drink that you think exacerbates your condition and/or makes it worse?
- Is there anything you notice makes it better?

Do you now undertake or have you undertaken a restricted diet? Please describe and indicate when:

PAST HEALTH PROBLEMS

List all major health problems you've had in the past five years.

Problem	Year
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FAMILY HISTORY

Circle any significant family health history in parents (Mother/Father), grandparents (GM/GF), and siblings(S) and indicate with initial(s) who had what:

Diabetes(), Cancer(), heart problems(), Mental illness(), Asthma(),

heart disease(), tuberculosis(), gout(), epilepsy(), thyroid problems(),

obesity(), eating disorders(), MS()

Other_____





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CURRENT STATE OF EMOTIONS AND FEELINGS

Please take a moment to answer the following questions:

- Is there an excess of stress in your life?
- What is causing the stress?
- Do you feel able to express your feelings and emotions?
- Are you satisfied with your job?
- If in a relationship, are you satisfied with it?
- Are you lonely?
- If there is one thing in your life you would like to change right now, what is it?
- Do you feel you have the ability or tools to change it?
- Are you a "nervous type" person? What are the things that make you most nervous?
- Have you a "super woman/superman" complex?
- Do you sleep well?
- Do you dream? Do you remember your dreams?
- Are you satisfied with your general energy level?
- Do you often feel exhausted and fatigued?
- Is it easy to wake up in the morning?
- **Which of these feelings dominate in your life (circle three):**

Joy happiness anger sadness fear sympathy worry depression anxiety peace

If you were to choose one or two Emotions that seem predominant in your life they would be: _____ and _____

Please indicate approximate dates and describe the nature of any traumatic experiences you have experienced in the past 7 years (such as divorce, loss of lover, loss of job, change of residents, accidents, injury, death, etc.)

Year

Event

FOR WOMEN ONLY:





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Contraceptive History

List the kind(s) of contraceptives you have used, if any, and for how long

BC Pills	Rhythm
IUD	Mucous Method
Diaphragm	Astrological
Condoms	Chemical Spermicides

Pregnancy History

List each pregnancy you have had, including miscarriages and abortions

Pregnancy/Date(s)	Miscarriage/Date(s)
Abortion/Date(s)	

Check any of the following problems that are currently happening in your life

General

<input type="checkbox"/> Vaginal Fibroid	
<input type="checkbox"/> Uterine Cysts	
<input type="checkbox"/> Endometriosis	
<input type="checkbox"/> Cervical Dysplasia	
<input type="checkbox"/> Pelvic Pain	When? How Long?
<input type="checkbox"/> Painful intercourse	
<input type="checkbox"/> Swelling of hands, feet, ankles	
<input type="checkbox"/> Vaginal Infection	How Long? What type?





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- | | |
|--|----------------------------|
| <input type="checkbox"/> Breast Pain | When in Cycle? |
| <input type="checkbox"/> Breast lump | Does it change with cycle? |
| <input type="checkbox"/> Breast Cancer | When was it diagnosed? |
| <input type="checkbox"/> Vaginal itching, discharge | How long? |
| <input type="checkbox"/> Difficulty in conceiving | |
| <input type="checkbox"/> General Fatigue, exhaustion | |
| <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Headaches | Migraines? |
| <input type="checkbox"/> Pelvic Inflammatory Disease | |
| <input type="checkbox"/> Infertility | |
| <input type="checkbox"/> Genital Herpes | |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Anemia | |

Menstruating Women

- | | |
|--|--------------------------|
| <input type="checkbox"/> Irregular menstrual cycles | |
| <input type="checkbox"/> Heavy menstrual bleeding | |
| <input type="checkbox"/> Bleeding between menstrual cycles | |
| <input type="checkbox"/> Painful Menstrual Cramps | What degree of severity? |
| <input type="checkbox"/> Absence of Menstrual Cycle | For how long? |
| <input type="checkbox"/> Dramatic Mood Swings around Menstrual Cycle | |





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Menopause

Hot Flashes

Dramatic Mood Swings Mild Mood Swings

Dry vaginal lining

Osteoporosis

Break Through Bleeding

ERT Therapy

any other Health concerns you feel are important to note?



Do not fill in below: For herbalist only

KEY PHYSICAL AREAS OF CONCERN





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- 1.
- 2.
- 3.

KEY EMOTIONAL AREAS OF CONCERN

- 1.
- 2.
- 3.

DIET

What foods to include:

What foods to reduce: _____

EXERCISE

Daily How much time





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Weekly How much time

HERBAL SUPPLEMENTS

Formula

What Form

How Much

How Often

1. Tea Formula
2. Tincture Formula
3. Capsule Formula
4. Vitamin/Mineral Supplements

SUPPORTIVE THERAPIES

Sitz baths, massage, counseling, etc.

- 1.
- 2.
- 3.





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4.

HOW LONG TO DO PLAN TO FOLLOW THIS PROGRAM

What are your Goals?

Weekly reports:

Week 1. _____

Week 2. _____

Week 3. _____

Week 4. _____

AT THE COMPLETION OF THIS PROGRAM





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- Did you follow the Program?
- What was easiest part for you to follow?
- What was the most difficult part for you to follow?
- Did you meet your expectations?
- Were you satisfied with the results?
- What would you do differently?
- Has this processed helped you in understanding better how to help others?

*"If you are not ready to alter your way of life, you cannot be healed"
.....Hippocrates*





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CONSENT TO TREATMENT

The law in Ontario requires that a client give informed consent to treatment. To fulfill this requirement, your practitioner must review the following information with you and you must sign this consent form before treatment begins.

The agreements between me, the client, and Our herbalists, the practitioner, are as follows:

1. That our herbalists are Registered Herbalists with a Diploma in Chartered Herbalist from Dominion Herbal College, BC and are *not* a medical doctor. I acknowledge that these are complimentary therapies to conventional medical care and that attend these sessions does not negate my need to maintain regular conventional medical care from a qualified medical doctor. I understand that in the event of a medical emergency, I am advised to seek medical care at a hospital or from a physician.
2. That any procedures or treatments will be explained to me prior to being performed, including any possible benefits or adverse effects. I understand that I may ask questions about the procedures or treatments at any time and may withhold my permission to have any procedure or treatment performed at any time.
3. That these therapies are necessarily interactive, and I am fully involved in the process of my healing.
4. That I have a written record will be kept of my course of treatment, and that my privacy and personal information will be held in strict confidence unless written permission is given by me, or where required of the practitioner by law.

Please initial each of the following statements.





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_____ I am aware that there are possible reactions and risks associated with treatments and knowingly assume these risks. No guarantees have been made to me concerning the results that may be achieved.

_____ I have accurately completed the health history form and have informed my consultant of all my present and past conditions.

_____ I understand that cancellation with less than 24 hours' notice will result in a charge of half the agreed upon fee and for a missed appointment without notice, full payment is expected.

_____ I freely and knowingly consent to the mutually agreed upon course of treatments as recommended by any herbalist working for Everything Herbal.

_____ By my signature, I acknowledge and fully understand the contents and implications of this consent form. I hereby release and discharge Everything Herbal and all its representatives from any and all claims, demands, damages, rights or actions, or causes of actions, present or future, resulting from these treatments.

Client Name: _____

Client (or guardian's) Signature: _____ Date: _____

