Lily Kunning, Community Herbalist: Personal Health Evaluation

This detailed intake form has many questions that may or may not pertain to your condition. These questions are searching for potentially undiagnosed conditions and connections between ailments. **Please answer all questions (we know it is long, sorry about that!) and bring to your initial consult.** Be sure and read the statement at the end and sign. Thanks!

I. Personal Information

Name_____

Age _____ Sex _____ Height_____Weight _____ Eye Color _____

Phone Number or Skype Number you wish to be contacted at _____

Email address: _____

Relationship status_____ Children_____ Occupation_____

Who do you share your home with? Is this a stressful relationship?

Main Reason for visit (diagnoses, main complaints and symptoms)

Other known health issues:

Do you feel like you are under stress? If so, explain.

How does your body manifest stress?

❑ Digestive Upset

❑ Muscle Tension

❑ TMJ or teeth grinding

❑ Mood Swings

❑ Anger

❑ **Other (specify)**

II. Current & Family Medical History

Please list all physicians and other healthcare providers or consultants (such as Acupuncturist, massage therapist, etc) you see on a regular basis:

Name Location Type of Service

_____
_____
_____
_____
_____

Would you like me to contact them regarding your health plan with me?_____

Family Medical History (Please describe any relevant or major health-related issues that you know of):

Father: _____
_____
_____
Mother: _____
_____
_____
Maternal Grandmother: _____
_____
_____
Maternal Grandfather: _____
_____
_____
Paternal Grandmother: _____
_____
_____
Paternal Grandfather: _____
_____
_____
Other family members with pertinent issues, or recurring family health trends:
_____
_____

III. Diet and Nutrition

a. On average, how many servings do you have per day of the following.

Food (serving size)	How many daily?	Food (serving size)	How many daily?
Fresh Fruit (½ c)		Butter (1 oz)	
Fresh Veggies (½ c)		White Bread (1 slice)	
Green Leafy Veggies (½ c)		Refined Sugar (1 teaspoon)	
Fresh/Frozen Fish (3-4 oz)		Cookies, Cakes, Pastries	
Poultry (3-4 oz)		Alcohol (1 oz)	
Red Meat (3-4 oz)		Soda Pop (8 oz)	
Seafood (3-4 oz)		Artificial Sweeteners	
Milk (1 c)		Non-dairy milk (1 c)	
Margarine (1 oz)		Processed, Pre-Made food	

What's a good day of eating like?

Breakfast: _____

_____

A.M. snack(s): _____

Lunch: _____

_____

Dinner: _____

_____

Evening snack(s): _____

_____

Daily water consumption (# glasses/quantity/day): _____

What's a bad day of eating like (meals on the run, etc): Breakfast:

_____

_____

A.M. snack(s): _____

Lunch: _____

_____

Dinner: _____

_____

Evening snack(s): _____

_____

Daily water consumption (# glasses/quantity/day):

_____

How many times a week do you have a good day_____Bad day_____of eating?

Please list any known food allergies/sensitivities (on back if needed): Food/Describe Reaction	Have you ever had herb tea?_____ What kind of water do you drink? _____ How is your digestive system overall, do you experience indigestion, gas, constipation, diarrhea, bloating or other?
What nutritional supplements are you currently taking (list on back)?	How often do you have a bowel movement?
	How often do you urinate and what is the character of your urine, i.e., light, dark, strong odor?
If everything was good for you, what would you want to eat (What do you crave)?	Do you rise in the middle of the night to urinate? How often?

IV. General Health Practices

How much sleep do you get each night on the average? _____ hours.

How do you sleep?

How often do you exercise? _____ hours per _____ .

List form and frequency of any regular exercise: _____

Common Physical Activities

__Desk Sitting (how long) __Sitting in a car (how Long) __Calisthenics __Swimming

__Walking __Tai Chi __Bike Riding __Tennis __Other_____

__Standing (how long?) __Jogging/Running __Aerobics __Weight Lifting __Yoga

__Hiking __Horseback Riding __ Bending/Lifting

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

Have you had any operations? ____What year? _____
_____
_____
Any major injuries/accidents?____ What and when? _____
_____
_____
Any major illness or hospitalizations? ___What and when? _____
_____
_____
What is your energy level like? _____

Are you pregnant or nursing a baby? _____

Current State of Emotions and Feelings

Are you able to express your feelings and emotions?	Are you a "nervous type" person?
Is there an excess of stress in your life?	What are the things that make you most nervous?
What is causing the stress?	Do you sleep well?_____How long each night?
Are you satisfied with your job?	Do you nap?_____ How long and often?
If in a relationship, are you satisfied with it?	Do you dream?_____ Do you remember your dreams?
If there is one thing in your life you would like to change right now, what is it?	Are you satisfied with your general energy level? Do you often feel exhausted and fatigued?
Can you change it?	Is it easy to wake up in the morning?
Have you a "super woman/superman" complex?	

Which of these feelings dominate in your life:

joy happiness anger sadness fear sympathy worry depression

If you were to choose two Emotions, which seem predominant in your life they would

be_____and_____

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

Year/Event

_____
_____
_____

Name one thing in life that you do that is really good for you: Name one thing you know you should be doing but don't: What are your passions and interests? What do you do for fun?	Do you currently smoke tobacco (y/n)? _____ If so, how many cigarettes/day? _____ If not, have you ever been a smoker in the past (y/n)? _____ For how many years did you smoke? _____ When did you quit? _____ Do you currently drink alcohol (y/n)? _____ If so, list type, quantity, and frequency: _____ Did you consume alcohol in the past (y/n)? _____ When did you quit alcohol? _____ If so list type, quantity and frequency:_____

V. Medical Information

a. Are you under a medical doctor's care for a condition? Which one(s)?_____

I f so, what are you being treated for?

b. Are you currently taking any prescription or over-the-counter drugs?

If so, please list each drug and what it is for on the other side.

What medications, medical procedures, supplements or therapies have you previously tried for your condition (list on back; or attach separate sheet if necessary)? Were any of these supplements or therapies helpful? If so, please note which ones were helpful.

c. Have you been diagnosed by a licensed physician with any of the following? Check all that apply.

❑ AIDS
❑ Angina
❑ Arthritis (Rheumatoid)
❑ Arthritis (Osteo)
❑ Arrhythmia (irregular heart beat)
❑ Asthma
❑ Attention Deficit Disorder (ADD/ADHD)
❑ Autoimmune Disorders, Specify:
❑ Benign Prostatic Hyperplasia (BPH)
❑ Bipolar Mood Disorder (Manic Depressive Disorder)
❑ Bleeding Disorders
❑ Cancer, Specify type:
❑ Cardiac Arrest (Heart Attack)
❑ Celiac Disease
❑ Chronic Obstructive Pulmonary Disorder (COPD)
❑ Cirrhosis of the Liver
❑ Colitis
❑ Congestive Heart Failure
❑ Depression
❑ Diabetes
❑ Eczema
❑ Endometriosis
❑ Epilepsy
❑ Fatty Liver Disease
❑ Fibromyalgia
❑ Graves Disease (Hyperthyroid)
❑ Hashimoto's Disease (Thyroiditis)
❑ Hepatitis
❑ High Blood Pressure (Hypertension)
❑ Irritable Bowel Disorder (Crohn's or Colitis)
❑ Kidney Stones
❑ Low Thyroid (Hypothyroid)
❑ Lupus
❑ Multiple Sclerosis
❑ Obsessive-Compulsive Disorder
❑ Osteoporosis or Osteopenia (circle one)
❑ Psoriasis
❑ Ulcers

Other, specify:

VI. Specific Symptoms

a. Check any of the following emotions you find it difficult to deal with, either in yourself or others.

Emotion	Problem Expressing Yours	Problems with Others Expressing
Anger		
Irritability		
Frustration		
Anxiety		
Fear		
Sadness		
Depression		
Excitement		
Laughter		
Lack of enthusiasm		
Lack of joy		
Worry		

b. Digestive, Liver and Intestinal Symptoms. Check all that apply.

❑ Abdominal pain or discomfort	❑ Food sits heavy on stomach after meals
❑ Acid indigestion, heartburn or acid refux	❑ Groggy feelings in the morning
❑ Bad breath	❑ Hard, dry stools
❑ Bloating, belching or intestinal gas	❑ Hemorrhoids or anal fstula
❑ Constipation (bowel movements less than once per day)	❑ Loss of appetite or poor appetite

❑ Cravings for sugary foods ❑ Diarrhea or loose stools ❑ Food allergies, specify foods that give you problems:	❑ Loss of smell or taste ❑ Sensation of lump in throat ❑ Stomachache ❑ Under weight or unable to gain weight

c. Respiratory System Symptoms. Check all that apply.

❑ Chronic or frequent cough ❑ Cold sores ❑ Earaches ❑ Excess mucus production ❑ Frequent infections ❑ Hayfever and respiratory allergies	❑ Itchy nose or ears ❑ Post nasal drip ❑ Sinus headaches ❑ Sinusitis or chronic sinus congestion ❑ Sore Throat ❑ Wheezing or shortness of breath

d. Circulatory System Symptoms. Check all that apply.

❑ Anemia ❑ Chest pain ❑ Cold hands and feet ❑ Family history of heart disease ❑ Gingivitis or gum disease ❑ Heart palpitations ❑ High blood pressure, specify blood pressure numbers:	❑ High cholesterol, specify: ❑ High triglycerides, specify: ❑ Irregular heart beat, arrhythmia ❑ Rapid heart beat ❑ Swelling in lower extremities ❑ Varicose veins or spider veins ❑ Wounds that won't heal in the extremities

e. Urinary and Fluid System Symptoms; Glandular System. Check all that apply.

❑ Bladder infections ❑ Blood in the urine ❑ Burning or painful urination ❑ Difficulty starting urination ❑ Excessive perspiration ❑ Frequent pale urine ❑ Frequent urination ❑ History of kidney stones	❑ Night sweats ❑ Pain in the mid to low back ❑ Puffyness under eyes ❑ Scant, dark urine ❑ Urinary incontinence (dribbling) ❑ Urinary tract infections (UTIs) ❑ Water retention or edema ❑ Swollen lymph nodes

f. Reproductive (Men and Women) issues:

❑ Burning sensations in hands and feet ❑ Cold hands and feet ❑ Dark circles under eyes ❑ Dry skin ❑ Excess weight ❑ Excess weight around the abdomen ❑ Fatigue in the afternoons ❑ Fatigue, chronic or excessive ❑ Feeling chronically stressed ❑ Feeling exhausted, "burned-out" ❑ Frequent thirst ❑ Hair loss or thinning ❑ Lack of stamina ❑ Loss of short-term memory ❑ Low body temperature, easily chilled	❑ Mental sluggishness, "brain fog" ❑ Mood swings ❑ Muddled thinking, confusion ❑ Restless disturbed sleep ❑ Restless dreams or nightmares ❑ Waking up at night unable to go back to sleep ❑ Waking up frequently at night ❑ Difficulty urinating ❑ Erectile dysfunction ❑ Infertility ❑ Lack of sex drive ❑ Loss of self-confidence and drive ❑ Nighttime urination ❑ Prostate problems ❑ Urinating at night

f. continued Reproductive Issues (Additional for Females Only):

❑ Cravings for chocolate with periods	❑ Nursing (currently)
❑ Depression with periods	❑ Painful menstruation
❑ Edema or bloating associated with periods	❑ PMS
❑ Heavy menstrual bleeding	❑ Post-menopausal
❑ Hot flashes and/or night sweats	❑ Pregnant (currently)
❑ Irritability with periods	❑ Vaginal discharge
❑ Menstrual cramps	❑ Vaginal dryness

g. Nervous System Symptoms. Check all that apply.

❑ Absent-mindedness	❑ Tension headaches with tight, constricted feeling
❑ Alcoholism	❑ Pounding headaches (like head is exploding
❑ Anxiety, nervousness	❑ Headaches around eyes or forehead
❑ Chronic muscle tension	❑ Migraines
❑ Difficulty getting to sleep	❑ Loss of memory
❑ Dizziness or light headedness.	❑ Panic attacks
❑ Excitability, difculty relaxing	❑ Peripheral neuropathy
❑ Feeling depressed or discouraged	❑ Poor concentration
❑ Headaches	❑ Shaky hands

h. Structural System Symptoms. Check all that apply.

❑ Acne	❑ Muscle cramps
❑ Arthritis	❑ Neck pain
❑ Back pain	❑ Osteoprosis
❑ Brittle fingernails	❑ Rashes
❑ Eczema	❑ Rosacea
❑ Gout	❑ Stiff, aching or painful muscles
❑ Itching, skin	❑ Teeth grinding
❑ Joint pain	❑ Tense muscles
❑ Leg cramps or pains	❑ Weak legs, knees or ankles
❑ Multiple root canals	

Add any additional information you feel may be helpful in evaluating your situation.

STATEMENT OF UNDERSTANDING

The human body has the innate power to heal itself. Without this power to self-heal, even the most advanced medications and surgical procedures would ultimately fail. The role of the herbalist in this healing process is to consider the client as a whole person and to consult with the client concerning changes in lifestyle, diet, and supplementation of herbs and/or vitamins to foster an increased state of balance and health, thus maximizing the body's self-healing capabilities.

I practice nutrition and lifestyle related assessment, diagnosis, and therapeutic methods based on the body's own healing system. This scope of practice includes dietary assessment, dietary changes, physical diagnosis related to nutrition (including pulse, palpation, tongue, and observation), interpretation of laboratory values relating to nutrition, dietary counseling, reviewing medical records, recommending diet therapies, recommending nutritional and herbal supplements when indicated, and identifying proper treatment strategies- all with the goal of achieving a healthy homeostasis.

My approach is to combine numerous alternative healing methods together with the latest scientific findings and clinical practices. Nutrition, lifestyle, and herbs are my primary specialty and represent my area of expertise. The degree of incorporation of these systems will vary from case to case. The basic principle is to help the body's natural capacity to restore balance, health, and harmony. Assessments are focused on identifying patterns and imbalances. Depending on the patient's wishes, recommendations may incorporate nutrition, herbs, supplements, counseling, exercises and lifestyle. Recommendations may be use to instill physical, emotional, mental, and/or spiritual balance.

I am NOT a Medical Doctor nor do I practice western medical assessment, diagnosis, or treatment. I do not claim to cure disease. Nor do I give advice about pharmaceuticals and medications at any time. I have no objections to my clients being seen or evaluated by their own medical doctor. If you have any questions or concerns about your condition, I highly recommend you discuss it with your physician. I am willing to work as part of a health care team including physicians and other health care providers and often do. If you would like me to work with your physician, please inform your physician also of this wish. I also recommend you inquire and explore any recommendations I provide with any professionals in health care.

Further, I create customized herbal formulas to fit the exact profile for what I feel clients need. Clients are not obligated to buy any products. I encourage clients to buy any supplements wherever it is most convenient for them, and I also make and sell many herbal products and some food products for a profit. I dispense them directly as a convenience and to ensure patients are receiving the specific, individualized herbal formula they need. I use mostly regional herbs that can be grown and/or wildcrafted in my area.

The recommended nutritional/herbal supplements are not a replacement for the medications prescribed by your Medical Doctor.

Please sign below once you have read and understood the above statement:

Name (print)_____ Date: _____
Signature_____

Due to HIPPA privacy regulations, your information will be held confidential and not shared with anyone.