Kathleen Gould, Herbalist RH (AHG) Kathy@swherb.com

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Herbs & Supplies *Specializing in Bulk Medicinal Herb Classes* *Consultations by Appointment*

CLIENT HISTORY

Name: _____Date: _____
Address: _____
City/State/Zip: _____
Phone (home): _____ (work) _____
Email: _____

Occupation: _____Date of Birth_____
Weight: _____ Height: _____Marital Status: _____
Number of Children/ages: _____
Spouse name:_____
Reason for visit: _____
_____
Going on for how long? _____
Is problem consistent or does it come and go? _____

Worse at certain times i.e. after eating, stress, hot/cold (please explain) _____
_____

Anything that relieves problem i.e. sleep, eating (please explain) _____
_____

List prescription drugs you are now taking _____
_____

List vitamins/mineral/herb supplements you are now taking _____
_____

MEDICAL HISTORY

Illnesses or surgeries: _____
_____

Number of pregnancies: _____ Number of births (explain) _____

Accidents/Dates (explain): _____
_____

Allergies (food, medication, other) explain: _____
_____

Have you seen a doctor for this problem? _____ Diagnosis: _____
Were tests run and if so what were results? _____
_____

What other forms of healing have you tried (meditation, acupuncture etc.) and what were results?
_____
_____

*What do *you* think the problem is? _____
_____

*What do *you* think *you* need to do to get well? _____
_____

Do you smoke? _____ How much _____ Alcohol _____ How much _____
Do you exercise _____ How long/how
often_____
Birth control _____ What form_____ How long taking
_____

DIET

Has your diet changed recently? _____ Have you taken a trip out of the country lately_____
Do you eat much ~ red meat _____ poultry _____ fish _____ dairy _____bread (white or wheat) _____ caffeine (coke, coffee) how much _____ chocolate _____ refined sugar _____ fruits(how much a day) _____ vegetables (how much a day) _____ salt _____ fried foods _____ whole grains _____ other (specify) _____

FAMILY HISTORY

Please list any illnesses that your are aware in your family i.e.cancer, heart disease, diabetes…

Mother
Father
Brother(s)
Sister(s)
Other

BODY SYSTEMS

(Please answer yes or no, if yes, please explain)

Circulatory System

Do you have chest pains? _____
When do you notice them (exercise, stress, at rest) _____
Palpitations _____
Shortness of breath _____
When _____
Slow wound healing? _____
Bruise easily? _____
Varicose veins? _____
Hemorrhoids? _____
Fainting _____
What is your blood pressure _____

Urinary System

How much water/fluid do you drink daily _____
Do you retain water _____
When urinating is there pain _____, burning _____ other _____
Is there constant or urgent need to urinate or producing to little urine _____
What color is urine _____

History of kidney infection
_____
Urinary/bladder infections
_____
Stones
_____
Lower back pain
_____

Muscular Skeletal System

Have you had or are you now experiencing any of the following:
(if yes, please explain)
Joint pain _____
If yes is it better with rest or movement _____
Swelling _____
Broken bones _____
Gout
_____
Other
_____

Digestive System

Chronic constipation _____
How long _____
Diarrhea or loose stools _____
How long _____
Blood or mucus in stools _____

Appetite good or poor _____
Gas or heartburn _____
Ulcers _____
Bloating _____
Pain after eating _____
How long after eating _____
Upset stomach _____
Bad breath _____
Tooth problems _____
Liver problems _____
Gallbladder problems _____

Reproductive System – Female

Is menstrual cycle regular _____
Is flow heavy, light or regular_____
Cramps _____
PMS (explain) _____
_____
Yeast infections (how often/how severe) _____
_____

Male

Urinary infections_____
Prostate problems _____

Nervous System

Do you have problems with:
Stress _____
Mood swings _____
Depression _____
Migraines _____
Insomnia _____
Snoring _____
Vision problem_____
Hearing problem _____
Fainting _____
Dizziness _____

Endocrine System

Do you have problems with:
Thyroid gland _____
Adrenal glands _____
Pancreas _____
Spleen _____
Other _____

Skin

Is your skin dry, oily or combination _____
Do you have skin eruptions i.e. acne, rash, boils etc (please explain)

Is hair oily/dry_____
Dull/shinny _____
Dandruff _____
Fungus on nails of feet or hands (explain) _____

Is there anything I have not asked that you feel I need to know? _____

Of all you have listed here today, what is the most important and which would you like to work on first?

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INFORMED CONSENT

Kathleen Gould is an Herbalist. At this time Herbalists are not licensed in the United States. We will discuss nutritional status and how the use of herbs, vitamins, minerals, dietary modifications and lifestyle changes may contribute to an increased sense of well being. Kathleen will be making suggestions; these suggestions are based on historical use of herbs. Please understand there is very little "scientific proof" on these products and the effect they may have on your body. You are unique, you know your body better than anyone, heed its communication. If you are currently on pharmaceutical medicines, please know that there are even fewer "scientific studies" on the interactions between drugs and supplements.

Kathleen is a teacher. Today you may learn more about balancing your body so that you feel better. Any lifestyle change or nutritional supplement (including herbs) that you decide to use is your decision alone. No one modality of healing can "cure". If you are working with other health care providers (including your MD) you may chose to discuss your decision with them.

Remember, healing comes from within; everything else is simply a tool.

Date: _____

Name: _____

Address: _____

Phone: (H) _____ (W) _____

Signature: _____

Please print name: _____