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Clinical Herbalist



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Name: _____ Date: _____ Referral Source: _____

Address: _____ Phone: _____ Cell: _____

City/State/Zip: _____ Email: _____

Date of Birth _____ Age _____ Place of Birth _____ Ethnicity _____

Where and when have you lived or traveled outside the U.S. or Canada? _____

Occupation: _____ How long? _____

On a scale of 1 to 10 (high) how stressful is your job? _____

Previous occupation _____ Education (Highest level attained) _____

Marital (Union) status _____ Number of times: Divorced _____ Widowed _____

Primary Physician: _____ Phone: _____

May we consult with your physician? ___yes ___no

Emergency contact: _____ Phone: _____

Most you have weighed as an adult _____ Year _____

Least you have weighed as an adult _____ Year _____

What concerns would you like to address and how long have they been an issue?

1. _____
2. _____
3. _____

In order to change these conditions, are you willing to make lifestyle modifications?

Yes _____ No _____ Maybe _____

What other health related issues have you had in the past?

Year/Condition _____

Year/Condition _____

Year/Condition _____

Family

Relationship Alive/Deceased Present health or cause of death

Father _____

Mother _____

Brothers _____

Sisters _____

Children/ages _____

Check illnesses which have occurred in any of your blood relatives:

Diabetes Cancer Bleeding Tendency Kidney Disease Tuberculosis Allergy Heart Disease

Stroke High Blood Pressure Nervous Illness Other _____

List the types of foods you eat for:

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Snacks & Times eaten _____

What foods do you crave? _____

What food do you react to? _____

What food do you NOT like? _____

Have you had allergies or sensitivity to medicines or other substances? No _____ Yes _____

List: _____

Do you Use:

	Now	In the Past	Type	Amount/Day	For how long?
Tobacco	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____
Coffee/Caffeinated Tea	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____
Recreational Drugs	_____	_____	_____	_____	_____

List the type of exercise you get in a typical week.

Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____

Medications currently or previously (in last year) used

Name	Dosage/Frequency	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements/vitamins/herbs currently used

Name	Dosage/Frequency	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any major health conditions: _____

LOWER GI

<input type="checkbox"/> Constipation with gas	<input type="checkbox"/> Stools loose with gas
<input type="checkbox"/> Frequent constipation	<input type="checkbox"/> Digestion unusually rapid
<input type="checkbox"/> Light colored, hard stools	<input type="checkbox"/> Loose stools when tired/stressed
<input type="checkbox"/> Intestines often bloated	<input type="checkbox"/> Dark, soft stools
<input type="checkbox"/> Constipation with hemorrhoids	<input type="checkbox"/> Quick defecation after eating
<input type="checkbox"/> Constipation with painful defecation	<input type="checkbox"/> Constipation w/ fully formed stools
<input type="checkbox"/> Constipation w/ hard, marbly stools	<input type="checkbox"/> Tongue often coated

UPPER GI

- | | |
|---|--|
| <input type="checkbox"/> Sometimes nausea in evenings | <input type="checkbox"/> Sometimes nausea in mornings |
| <input type="checkbox"/> Mouth frequently too dry | <input type="checkbox"/> Sometimes excess salivation |
| <input type="checkbox"/> Duodenal ulcer | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Sometimes foul burps | <input type="checkbox"/> Strong, demanding hunger |
| <input type="checkbox"/> Butterflies in stomach | <input type="checkbox"/> Seldom eat breakfast |
| <input type="checkbox"/> Often don't finish meals | <input type="checkbox"/> Often eat to calm down |
| <input type="checkbox"/> Receding gums | <input type="checkbox"/> Frequent use of alcohol |
| <input type="checkbox"/> Frequent poor appetite | <input type="checkbox"/> Bitter taste in morning |
| <input type="checkbox"/> "Dragon breath" in morning | <input type="checkbox"/> Acid indigestion at night |
| <input type="checkbox"/> Frequent mouth cold sores | <input type="checkbox"/> Sometimes difficulty swallowing |
| <input type="checkbox"/> Indigestion after eating | |

LIVER

- | | |
|--|--|
| <input type="checkbox"/> Dry, even scaly skin | <input type="checkbox"/> Moist, sometimes oily skin |
| <input type="checkbox"/> Hay fever or asthma | <input type="checkbox"/> Hives from food or drugs |
| <input type="checkbox"/> Craves fruit or sweet | <input type="checkbox"/> Craves proteins, fats |
| <input type="checkbox"/> Frequent trouble digesting fats | <input type="checkbox"/> Fever with sweat when sick |
| <input type="checkbox"/> Acne on face AND buttocks | <input type="checkbox"/> Seem to have low blood sugar |
| <input type="checkbox"/> Had hepatitis in past | <input type="checkbox"/> Frequent use of alcohol |
| <input type="checkbox"/> Work with solvents | <input type="checkbox"/> Psoriasis, eczema, dermatitis |
| <input type="checkbox"/> Frequent minor illnesses | <input type="checkbox"/> Don't sweat when sick |

RENAL

- | | |
|--|---|
| <input type="checkbox"/> Standing too quickly causes faintness/dizziness | <input type="checkbox"/> Wakes up at night to urinate |
| <input type="checkbox"/> Standing too quickly makes pulse roar in ears | <input type="checkbox"/> Frequent water retention |
| <input type="checkbox"/> Frequent flushing or blushing | <input type="checkbox"/> Urine usually dark |
| <input type="checkbox"/> Moderate low blood pressure | <input type="checkbox"/> Moderate high blood pressure |
| <input type="checkbox"/> Frequent thirst | <input type="checkbox"/> Craving for salt |
| <input type="checkbox"/> Urine always light colored | |

LOWER URINARY TRACT

- | | |
|--|--|
| <input type="checkbox"/> Frequent urination, small amounts | <input type="checkbox"/> Infrequent urination, copious |
| <input type="checkbox"/> Sometimes dribble afterwards | <input type="checkbox"/> Frequent bladder infections |
| <input type="checkbox"/> Demanding need to urinate | <input type="checkbox"/> Mucus in urine |
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> Dull ache after urination |

REPRODUCTIVE

- ___ Dry skin, cold hands and feet
- ___ Oily skin, facial acne

- ___ Sweat freely with strong scent

WOMEN

- ___ Cycle more than 28 days
- ___ Miss some periods
- ___ Menses slow starting with cramps
- ___ Frequent Class II Pap smear
- ___ History of PID, cervicitis
- ___ Miscarriages, problem pregnancy
- ___ Period late with altitude change
- ___ Hot Flashes
- ___ Constipation before, loose stools after menses starts

- ___ Cycle less than 28 days
- ___ Water retention before menses
- ___ Menstruation always lengthy
- ___ Always hungry before menses
- ___ Breasts tender before menses
- ___ Palpitations before menses
- ___ Period early with altitude change
- ___ Negative reaction to birth control pills

MEN

- ___ Frequent cannabis user
- ___ Difficulty maintaining erection when in mood
- ___ Pain or ache after orgasm
- ___ Benign prostatic hypertrophy

RESPIRATORY

- ___ Easy coughing of mucus
- ___ Tobacco smoker
- ___ Difficulty swallowing mucus
- ___ Shortness of breath when standing or walking
- ___ Sometimes wake up choking or gasping for breath
- ___ Yawns frequently
- ___ Sometimes hyperventilates
- ___ Rapid, shallow breather
- ___ Frequent chest colds

CARDIO-VASCULAR

- ___ Fast, light pulse
- ___ Cold bodied
- ___ Sometimes dizzy or faint
- ___ Hands cold, clammy or dry
- ___ Hypertension, not responding to diuretics
- ___ Hypertension responds to diuretics
- ___ Palpitations either as an adolescent or before menses
- ___ Slow, strong pulse
- ___ Frequent physical activity
- ___ Warm bodied
- ___ Hands warm, sweaty

LYMPHATIC

- | | |
|--|---|
| <input type="checkbox"/> Recuperates slowly if ill | <input type="checkbox"/> Recuperates quickly if ill |
| <input type="checkbox"/> Injuries heal slowly | <input type="checkbox"/> Injuries heal quickly |
| <input type="checkbox"/> Eczema, dermatitis | <input type="checkbox"/> Asthma or hay fever |
| <input type="checkbox"/> Arthritis or rheumatism | |

SKIN

- | | |
|---|---|
| <input type="checkbox"/> Skin eruptions are deep, not coming to a head | <input type="checkbox"/> Skin on trunk is dry |
| <input type="checkbox"/> Skin eruptions are superficial, come to a head | <input type="checkbox"/> Oily scalp or hair |
| <input type="checkbox"/> Cracks, fissures on heel, elbow, feet, heal poorly | <input type="checkbox"/> Dry scalp or hair |

MUCUS

- | | |
|---|--|
| <input type="checkbox"/> Sores, cracks, fissures in mouth, anus, vagina | <input type="checkbox"/> Lips often dry, chapped |
| <input type="checkbox"/> Food often causes intestinal distress as it passes | <input type="checkbox"/> Gets sore throat easily |

GENERAL

Mark all that apply. If mild, mark "1"; if strong, mark "2".

- | | |
|--|---|
| <input type="checkbox"/> Awakens, can't go back to sleep | <input type="checkbox"/> Increase in weight (recent) |
| <input type="checkbox"/> Bad dreams | <input type="checkbox"/> Lack of sensation somewhere |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Likes depressants |
| <input type="checkbox"/> Brown spots, bronzing of skin | <input type="checkbox"/> Likes stimulants |
| <input type="checkbox"/> Bruises easily | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Can't gain weight | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Can't lose weight | <input type="checkbox"/> Nails split, brittle |
| <input type="checkbox"/> Can't get started without coffee | <input type="checkbox"/> Nose bleeds frequently |
| <input type="checkbox"/> Chemical or spray poisoning | <input type="checkbox"/> Pollution heavy in environment |
| <input type="checkbox"/> Chronic fatigue, depression | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Cry easily without apparent cause | <input type="checkbox"/> Pulse speeds up after meals |
| <input type="checkbox"/> Depressed for long periods | <input type="checkbox"/> Sensitive to cold weather |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Sensitive to hot weather |
| <input type="checkbox"/> Eat often or else faint/nervous | <input type="checkbox"/> Sensitive to high humidity |
| <input type="checkbox"/> Eyes often red/inflamed | <input type="checkbox"/> Sensitive to low humidity |
| <input type="checkbox"/> Face, eyes get puffy | <input type="checkbox"/> Sexual desire decreased |
| <input type="checkbox"/> Facial twitches | <input type="checkbox"/> Sexual desire increased |
| <input type="checkbox"/> Gum problems | <input type="checkbox"/> Stuffy nose during the day |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stuffy nose in evening/night |
| <input type="checkbox"/> Headaches in morning, wearing off | <input type="checkbox"/> Tendency to anemia |
| <input type="checkbox"/> Heart palpitations when hungry | <input type="checkbox"/> Tremors in hands or neck |

___ Heart palpitation after eating

___ Varicose veins

___ Highly emotional

___ Highly controlled

___ Weight gain in upper arms, shoulders, back of neck

___ Impaired hearing

Current State of Emotions and Spiritual Wellbeing

Take time to think about the following questions:

Are you completely satisfied with your living conditions? _____

Are you able to express your feelings and emotions? _____

Is there an excess of stress in your life? _____

What is causing the stress? _____

Are you in a healthy relationship? _____

Do you feel well supported? _____

Do you sleep well? _____

Do you dream? _____

Are you satisfied with your energy level? _____

Is it easy to wake up in the morning? _____

Do you enjoy your work? _____

Do you believe in a higher power? _____

Which of these feelings dominate your life? (Circle any that apply)

Joy Happiness Anger Sadness Fear Sympathy Worry Depression

Other? _____

Have you suffered from any stress inducing life events in the last 5 years? (ie: divorce, loss of a lover, loss of a job, change of residence, injury, death of a loved one, etc?) _____
