New Patient Herbal Consultation

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Name:_____ Birthdate:_____ Primary Care Dr._____

Please list (up to 3) major issues that brought you in today:

1. _____
a. How does this problem impact your life?

b. When did this start? What were the surrounding life events or emotions at that time?

c. Does anything (medication, activity, herbs, therapies) make this better or worse?

d. What else have you tried for this problem?

e. What changes have there been in this problem over time (better? worse? comes and goes?)

f. Is this better or worse at any time of day? day of week? time of month? time of year?

g. Do you notice other symptoms or feelings when this problem is worst?

h. Why do you think that you have this problem?

2. _____
a. How does this problem impact your life?

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g. Do you notice other symptoms or feelings when this problem is worst?

h. Why do you think that you have this problem?

Any other problems that don't make the top three?

Past Medical History:
What medical diagnoses do you have (include high cholesterol, blood pressure, etc.)?

What medical problems have you had in the past?

What surgeries have you had?

Have you been hospitalized? If so, for what?

What prescription or over-the-counter medications do you take? Please include dose, and feel free to attach a separate sheet if that is easier.

What supplements (herbs, vitamins, homeopathics) do you take (including dose)?

Do you have any allergies (medications, foods, environmental)?

How many times have you had antibiotics in the last 5 years?

Family History

Medical problems or disabilities:

Mother:	Father:
Mother's mother:	Father's mother:
Mothers's father:	Father's father:
Brothers/sisters:	

Children:

Where is your family from originally (multiple answers are fine)?

Describe what you know about your birth:

Social History
What do you do for work?
How many hours do you work? Are they regular hours? Night shift?

What are the major sources of stress in your life?

What were your previous jobs?

Are you satisfied with your life?

What do you do for fun or to recharge?

Do you have a religious or spiritual practice?

Do you feel God or Spirit in your daily life? When?

Do you do anything creative? What?

Who do you turn to for support? Do you get the support you need?

Who do you live with? Pets?

How much TV do you watch per day?
How much time do you spend in front of a computer each day?
How often have you moved in the last 5 years?
Any major life changes in the last year?
Are you in a romantic relationship? With whom? What is best and worst about it?

Are you comfortable with your sexuality?
Did you have a happy childhood? Was/is there abuse or alcohol/drug abuse in the home?

What do you do for exercise? How much per week?

How much sleep do you get on an average weeknight? Weekend night?
Do you have any trouble falling asleep? Staying asleep? Waking early? If so what keeps you up?

Do you remember your dreams?
How do you feel on waking up in the morning?
Do you spend time in nature?
What is your favorite time of day? Season?
Do you smoke? Did you ever? Do other people in your household smoke?
Any exposure to toxic materials?
Do you use other drugs? Have you in the past?

Diet

Please chose a typical weekday and weekend day and list everything you ate or drank over the course of the day. Include any snacks.

Weekday:

Food/Beverage	Time	Quantity	Food/Beverage	Time	Quantity

Weekend day:

Food/Beverage	Time	Quantity	Food/Beverage	Time	Quantity

How many of your meals are home cooked?

How often do you eat on the run or in front of the tv/computer?

How often do you eat with family or friends?

Are your meals rushed?

Do you have any food cravings?

Any food that you have a bad reaction to, or have a hard time digesting?

Do you have any guilt about food? If so what?

How many drinks per week with caffeine? Sugar? Alcohol?
How much of your food is micro waved?
What are the strong points of your diet?

What would you like to improve about your diet?

Review of Systems

Digestion
Belly pain? Describe.

How often do you have bowel movements?
How long does a bowel movement take?
Are your bowel movements hard/soft/liquid?
What color is your stool?
Is your stool unusually foul smelling?
Do you have gas?
Nausea/vomiting?
Bad breath?
Dry mouth?
Cavities/dental work?
Heartburn/ulcers/hernias?
Have you ever had a colonoscopy? When was your last one?
Anything ever abnormal?
Ever had an eating disorder?
How much do you weigh? Is this weight OK with you?

Heart/Circulation
Do you easily feel warm or cold?
Do you sweat a lot?
Do you get cold hands or feet?
Do you get dizziness on standing?
Do you bruise or bleed easily?
Do you ever have chest pain?
Do you have varicose veins or hemorrhoids?
Do wounds take a long time to heal?
Have you ever been told that you have heart disease or anemia?

Respiratory
Do you have asthma or a chronic cough?
Do you ever feel short of breath? When?
How often do you get colds?
How often did you get sick as a child?
Do you ever have swollen glands?
Please describe how your breathing feels to you.

Nerves
When do you feel stress?

Does this worsen any of the things that are bringing you in?
How do you deal with stress?

Do you feel that you are more emotional or controlled?
What is the main emotion you feel these days?
How is your memory?
Do you have any of the following (circle)? Depression, anxiety, panic attacks, ringing in the ears, dizziness.
Do you have any of the following (circle)? Tremors, numbness, tingling, weakness.
Where?

Do you practice any relaxation techniques?

Head
Do you get headaches? How often? What brings them on? What makes them better?

Do you have any trouble with vision (glasses, contacts, blurry vision, double vision)?

Do you have any trouble hearing?

Reproductive
Both sexes
Do you use birth control regularly? If so, what kind?
Have you ever had a sexually transmitted disease?
Are you satisfied with your sex life?
Do you have a good sex drive?
Any rashes around your genitals, or any discharge from your genitals?

Women
Regular cycle? y/n
How long from the start of one cycle to the start of the next?
How many days of flow do you have?
How many pads/tampons do you use on the heaviest day?
How is your mood before your period?
Do have significant cramping/bloating with your periods?
Do you bleed between periods?
Do you have pain with intercourse?
How many pregnancies have you had? Any lost? Why?
If you have children, how were they delivered?
When was your last pap? Ever had an abnormal pap?
Have you been through menopause? When was your last period?

Men
Any trouble starting or maintaining erections? When?
Any weak stream of urine? Difficulty starting urination? Getting up at night to urinate?

Musculoskeletal
Any joint pain or stiffness? Which joints? When? What makes it better or worse?

Any muscle cramps?

Skin
Any rashes? Where? When are they worst? Please describe the rash.

Is your skin dry, oily, or sweaty?
Do you ever have bad body odor? When?
Is your hair thin or with bald areas?

Endocrine
Any recent weight change?
Mood swings when you don't eat?
Any changes in your energy level?
Do you feel hotter or colder than those around you?
Are you always thirsty?

Urinary
What color is your urine?
Does your urine have a foul odor?
Does it ever hurt to urinate?
Is your urine ever cloudy or foamy?

Conclusion
How would your ideal life look different from where you are today?

What stands between you and that life?

What would it take to overcome that barrier?

What strengths do you have that will help you solve this problem?

What should we address first?

What do you expect from me?

Anything else I should know?