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**CLIENT INTAKE AGREEMENT**

We appreciate you taking the time to review this information, complete the enclosed forms and supply us with the items requested below.

*Please fill out the following online forms prior to your appointment:*

1. Personal Health Profile
2. Informed Consent Form
3. 3-day journal of all your meals, snacks and beverages. Include times of day you are eating.

*Provide the following by email if appropriate:*

Most recent CBC blood work panel *and any other lab results if relevant to your health issues.*

If you are having a SKYPE or phone consultation, please provide a recent photo of your face, and tongue (tooth brushing is fine, do not scrape tongue please) and unpolished nails if possible.

**POLICIES AND PROCEDURES**

* If SKYPE or phone appointment, please fax/email the requested information to us 24 hours in advance of your scheduled appointment.
* If you are sending your forms via postal mail, please send 1 week in advance.

**INITIAL CONSULT - WHAT YOU SHOULD EXPECT**

Valerie will typically spend an initial 20-30 minutes of your appointment time reviewing the information you have brought in with you.

While you wait for her to prepare, she will review your health history, along with any labs or additional materials you have provided. Your practitioner will make nutritional, dietary, lifestyle and other recommendations. You will receive a written protocol, which includes the name and recommended dose of each herbal and nutritional compound.

**YOUR PROTOCOL**

Valerie typically gets the best results with a combination of very specialized nutritional and herbal supplements and a liquid herbal tincture, custom-blended for you. Dietary and lifestyle changes are essential to true healing and to facilitate the therapeutic response of the natural compounds and herbs. She may recommend exercise, dietary changes or other types of therapy, such as acupuncture or counseling, which may be helpful. Often, you will be encouraged to be still in meditation or prayer on a daily basis. The types of things she recommends are determined by your current health, constitutional evaluation, and your interest.

**RECOMMENDED PRODUCTS**

Part of our service to you is the benefit of our practitioner’s many years of experience and research in the health field. Because of this, her product recommendations are most often brand specific. She is very particular and uses only high-quality products with which she sees consistent, good therapeutic results. We stock a full dispensary of supplements, natural compounds and herbal preparations based on our practitioner’s research and experience. Many of these compounds are not found in health food stores as they are sold to practitioners only. With this consistency in product quality and potency, Valerie is better able to assess your progress.

**FOLLOW-UP CONSULTS**

These are set per the practitioner’s recommendation and by mutual agreement. Usually, a given protocol is followed for 1 to 3 months. For optimal results, you may need to be reassessed at that time so that appropriate changes can be made to the herbal formulation and nutritional protocol. If you run out of your supplements or tincture between appointments, you should get them refilled in order to continue your progress. You may, of course, schedule a consult prior to your follow-up if you have something in-depth you would like to discuss sooner.

**CLIENT QUESTIONS**

Our highly qualified office staff can answer many of your questions and otherwise act as liaison between clients and Valerie in order to get your questions answered quickly. Please call in your questions to us. She may have her staff call you with answers to your questions if they are straight-forward. Valerie will review all questions and respond within a day or two, or sooner for urgent issues.

**ORDERING PROCEDURES**

Sage Consulting & Apothecary offers an extensive Apothecary of herbal and nutritional formulations carefully chosen for their quality, purity, potency and clinical effectiveness. In order to receive items on your protocol, we must first receive your order in person, by phone, fax or email. Call our dispensary direct at 719-473-9702 or toll free at 833-473-4372 or email at [clinic@sagewomanherbs.com](mailto:clinic@sagewomanherbs.com).

**CANCELLATION POLICY**

* If you need to reschedule or cancel your appointment, please notify the office with at least 24 hours advance notice to avoid a cancellation fee.

* **Be advised that you will be charged $60 for a new consult, or $25 for a follow-up, if your scheduled is cancelled with less than 24 hours’ notice.**
* Thank you for your consideration of the practitioner’s time and of others waiting for appointments.

Click or tap here to enter text.

By clicking the box above and entering your name, you agree to the Cancellation Policy.

**INFORMED CONSENT FORM**

**NOTICE TO ALL STUDENTS & CLIENTS**

The United States of America currently has no licensing policy in regard to Herbal Medicine, and I, a clinical Herbalist, Valerie Ann Blankenship, am not a licensed Medical Doctor. I do not deal with drugs, nor do I issue a diagnosis or suggest cures.

My purpose is simply to educate my client and/or student and his or her body as to healing by natural processes. I consider herbs and foods to be nutritional assets to health and it is in this way that I offer my advice. Although I personally believe herbs are a part of good health care, I make no claims for their medicinal actions. Any information offered is done so on the basis of research and scientific evidence and traditional uses.

My clients/students agree to make their own choices as to what they do with the educational material they have been offered and are solely responsible for their own decisions and actions. It is always my suggestion that the client/student should seek out the advice of a licensed health care practitioner whenever they feel it is necessary in regard to their own personal health.

I have read the above statement and I understand and agree with it. My purpose to seeking the advice of Valerie Ann Blankenship is done so for educational and nutritional purposes only.

Click or tap here to enter text.

By clicking the box above and entering your name, you agree to the Informed Consent Form.

**PERSONAL HEALTH PROFILE**

“*If you are not ready to alter your way of life, you cannot be healed…*” Hippocrates

|  |
| --- |
| Name: Click or tap here to enter text. Age: Click or tap here to enter text.  Phone #: (HOME) Click or tap here to enter text.(CELL) Click or tap here to enter text.  Preference:  Home  Cell  Skype Address: Click or tap here to enter text.  Address: Click or tap here to enter text.  E-mail Address: Click or tap here to enter text. Referred by: Click or tap here to enter text.  Date of Initial Appointment:Click or tap here to enter text. Day of Week: Click or tap here to enter text.Time: Click or tap here to enter text. |

**KEY AREAS OF PHYSICAL CONCERN:**

In this section, list your main physical complaints on the lines below and rate them by severity on a scale of 1-10, with 10 being the most severe. Where is this issue currently?

|  |  |
| --- | --- |
| Health Issue | Severity |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

Have you seen any doctors or other therapists regarding the above health issues? If yes, please list below:

|  |
| --- |
| Practitioner Name(s) |
| Click or tap here to enter text. |
| Click or tap here to enter text. |
| Click or tap here to enter text. |

**HEALTH STATUS:**

Check each column below where symptoms apply.

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Cardiovascular | |
| High blood pressure | Previous stroke |
| Low blood pressure | Cold hands/feet |
| Pain upper left chest | Tingling arms/hands |
| Poor circulation | High cholesterol |
| Swelling ankles/joints | Poor cholesterol ratios |
| Heart Palpitations | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Muscles/Joints | |
| Backache upper/lower | Rheumatoid arthritis |
| Broken bones past/present | Stiffness in joints |
| Osteoarthritis | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Eyes, Ears, Nose & Throat | |
| Ear aches | Hearing loss |
| Eye pains, dry/teary | Excessive ear wax |
| Failing/worsening vision | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Urinary/Kidney | |
| Excessive urination | Up to urinate 1x night |
| Water retention | Up to urinate 2x’s night |
| Kidney stones past/present | Burning urination |
| Lower back stiffness/soreness | Dark, cloudy urine |
| Dark circles under eyes | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Skin | |
| Boils | Cysts |
| Bruises | Pimples |
| Dryness | Sores |
| Itching | Broken veins |
| Varicose veins | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Respiratory | |
| Difficulty breathing | Sinus infections |
| Cough | Asthma attacks |
| Sinus congestion | Post nasal drip |
| Frequent colds | Sore throat |
| Emphysema | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Gastrointestinal | |
| Belching | Indigestion |
| Colitis | 1 bowel movement/day |
| Constipation | 2 bm/day |
| Hepatitis | 1 bm/every other day |
| Gallstones | 2 or less bm/week |
| Ulcers | Blood in stools |
| Abdominal pain | Light colored stools |
| Abdominal cramps | Black, tarry stools |
| Burning esophagus | Frequent diarrhea |
| Gas | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **x = sometimes experience x x = occurs often x x x = major concern** | |
| Other | |
| Memory problems | Uncomfortable in moldy, damp rooms |
| Dizziness | Toenail fungus |
| Crave sweets, breads or alcohol | Sensitive to tobacco, chemical odors, perfume |
| Athlete’s foot, jock rash | Tongue coated heavy white/yellow in a.m. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Allergies | | | | |
| Do you have allergies? | No | | Yes, to what? Click or tap here to enter text. | |
| Medication or herb allergies | No | | Yes, to what? Click or tap here to enter text. | |
| Food allergies | No | | Yes, to what? Click or tap here to enter text. | |
| History | | | | |
| Have you had any operations? | No | | Yes, list with dates Click or tap here to enter text. | |
| Any major injuries/accidents? | No | | Yes, list with dates Click or tap here to enter text. | |
|  |  | |  | |
| Supplements  *(if you have more supplements than will fit on this form, please email a separate page)* | | | | |
| Name of supplement | | Dosage | | Used for what purpose? |
| Click or tap here to enter text. | | Click or tap here to enter text. | | Click or tap here to enter text. |
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| Medications | | |
| Name of medication | Dosage | Used for what purpose? |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Common Physical Activities | | | |
| Sitting at Desk (how long Click or tap here to enter text.) | | | Walking |
| Sitting in a car (how long Click or tap here to enter text.) | | | Yoga |
| Standing (how longClick or tap here to enter text. | | | Tao Chi |
| Jogging/running (Click or tap here to enter text. times per week) | | | Hiking |
| Aerobics | | | Bike riding |
| Swimming | | | Horseback riding |
| Weight-lifting | | | Tennis |
| Do any of the above activities aggravate a current health condition? | No | Yes, explainClick or tap here to enter text. | |
| Dietary Habits | | | |
| Canned Foods | | | Raw vegetables |
| Fresh vegetables | | | Cooked veggies |
| Red meat/non-organic | | | Desserts |
| Red meat/organic or game | | | Coffee ( Click or tap here to enter text. cups/day) |
| White sugar | | | Black tea (Click or tap here to enter text. cups/day) |
| Brown Sugar | | | Wine (Click or tap here to enter text. cups/day) |
| Honey | | | Other alcohol (Click or tap here to enter text. cups/day) |
| Sweet and Low, nutrasweet, etc | | | Cigarettes (Click or tap here to enter text. day) |
| Soft drinks w/ sugar ( Click or tap here to enter text. /day) | | | Salt (list type) |
| Soft drinks w/ nutrasweet ( Click or tap here to enter text. /day) | | | Soy |
| Butter | | | Kombucha |
| Margarine | | | Kefir or fermented food |
| Fruits, fresh | | | Coconut oil |
| Fruits, canned | | | Olive Oil |
| Canola, Wesson or Vegetable Oil | | | Click or tap here to enter text. |

Do you drink filter water or tap water?  Filtered  Tap

If you use a filter, what type and/or conditioner do you use? Click or tap here to enter text.

If delivered or purchased, is it distilled or reverse osmosis? Click or tap here to enter text.

How much water do you drink on a regular basis? Click or tap here to enter text.

**3-Day Diet Journal:**

List a typical day’s meals:

|  |  |  |
| --- | --- | --- |
| Time | Day 1 Food – **Date** Click or tap here to enter text. | Beverage(s) |
| Click or tap here to enter text. | Breakfast Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Snack Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Lunch Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Snack Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Dinner Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Desserts Click or tap here to enter text. | Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| Time | Day 2 Food – **Date** Click or tap here to enter text. | Beverage(s) |
| Click or tap here to enter text. | Breakfast Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Snack Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Lunch Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Snack Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Dinner Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Desserts Click or tap here to enter text. | Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| Time | Day 3 Food – **Date** Click or tap here to enter text. | Beverage(s) |
| Click or tap here to enter text. | Breakfast Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Snack Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Lunch Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Snack Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Dinner Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Desserts Click or tap here to enter text. | Click or tap here to enter text. |

**Family History:**

Check any significant immediate family health history:

|  |  |
| --- | --- |
| Family History | |
| Diabetes | Heart conditions |
| Asthma | Epilepsy |
| Cancer | Mental illness |
| Gout | Thyroid problems |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

|  |  |
| --- | --- |
| For Men Only | |
| Frequency of urination | Swollen prostrate |
| Hesitancy when urinating | Painful urination |
| Difficulty getting/maintain erection | Benign Prostatic Hyperplasia |

|  |  |
| --- | --- |
| For Women Only | |
| Used birth control? How long Click or tap here to enter text. | Hot flashes |
| Used hormone replacement therapy. How long Click or tap here to enter text. | Difficultly conceiving |
| Uterine fibroids | Dramatic mood swings |
| Uterine cysts | Pounding heart |
| Endometriosis | Dry vaginal lining |
| Cervical dysplasia | Osteoporosis |
| Pelvic pain. How long? Click or tap here to enter text. | Painful menstrual cramps |
| Painful intercourse | Absence of menstrual cycle |
| Genital herpes | Dramatic mood swings around cycle |
| Vaginal infection (type) Click or tap here to enter text. | Irregular menstrual cycles |
| Breast pain, related to cycle? Click or tap here to enter text. | Headaches (how frequent)? Last?  Click or tap here to enter text. |
| Breast lumps, change with cycle? Click or tap here to enter text. | Vaginal discharge (diagnosed)?  Click or tap here to enter text. |
| Pelvic Inflammatory disease | Vaginal infection (type) Click or tap here to enter text. |
| Break through bleeding or spotting between periods | Heavy menstrual bleeding during period |

**Constitutional Intake Form:**

|  |  |
| --- | --- |
| Upper GI - Mark mild = x; dominant = xx | |
| Sometimes nausea in the mornings | Receding gums |
| Sometimes nausea in the evenings | Frequent use of alcohol |
| Sometimes excess salivation | Frequent poor appetite |
| Mouth frequently too dry | Strong demanding hunger |
| Duodenal ulcer | Bitter taste in the morning |
| Stomach ulcer | “Dragon breath” in the morning |
| Sometimes foul burps | Acid indigestion at night |
| Butterflies in stomach | Frequent mouth/cold sores |
| Seldom eat breakfast | Sometimes difficulty swallowing |
| Often don’t finish meals | Indigestion after eating |
| Often eat to calm down | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Lower GI - Mark mild = x; dominant = xx | |
| Stools loose with gas | Intestines often bloated |
| Constipation with gas | Constipation with hemorrhoids |
| Frequent constipation | With painful defecation |
| Digestion unusually rapid | With hard, marbly stools |
| Loose stools when tired/stressed | With fully formed stools |
| Light colored, hard stools | Alternates with diarrhea |
| Dark, soft stools | Frequent need for laxatives |
| Quick defecation after eating | Tongue often coated |

|  |  |
| --- | --- |
| Liver - Mark mild = x; dominant = xx | |
| Dry, scaly skin | Acne on face AND buttocks |
| Moist, oily skin | Seems to have low blood sugar |
| Hives from food/drugs | Had hepatitis in the past |
| Hay fever or asthma | Frequent use of alcohol |
| Crave proteins, fats | Work with solvents |
| Crave fruit, sweets | Psoriasis, eczema, dermatitis |
| Frequent trouble digesting fats | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Respiratory - Mark mild = x; dominant = xx | |
| Shortness of breath when stand/walking | Sometimes wake choking/gasping for breath |
| Tobacco smoker | Yawns frequently |
| Easy coughing of mucus | sometimes hyperventilates |
| Rapid, shallow breather | Frequent chest colds |
| Difficulty swallowing mucus | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Lymphatic - Mark mild = x; dominant = xx | |
| Recuperates quickly if ill | Asthma or hay fever |
| Recuperates slowly if ill | Arthritis or rheumatism |
| Injuries heal quickly | Digests fats easily |
| Injuries heal slowly | Digest fats poorly |
| Eczema, dermatitis | Click or tap here to enter text. |

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| --- | --- |
| Skin - Mark mild = x; dominant = xx | |
| Sores, cracks on mouth, anus, vagina | Food often causes intestinal pain passing |
| Lips often dry, chapped | Gets sort throat easily |
| Frequent minor illnesses | Fever w/ sweat when sick |
| Do not sweat when sick | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Renal - Mark mild = x; dominant = xx | |
| Standing too quickly makes pulse roar in ears | Standing too quickly causes faint/dizziness |
| Wakes up at night to urinate | Frequent flushing or blushing |
| Water retention with change in weather | Moderate high blood pressure, crave fats |
| Moderate low blood pressure, craves sweets | Urine always light colored |
| Frequent thirst | Urine usually darker |
| Craving salt | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Lower Urinary Tract - Mark mild = x; dominant = xx | |
| Frequent urination, small amounts | Infrequent urination, copious |
| Sometimes dribbles urine afterwards | Demanding and sudden need to urinate |
| Frequent bladder infections | Mucus in urine |
| Benign prostatic hypertrophy (males) | Dull ache after urination |

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| Reproductive – All | |
| Sweat freely with strong scent | Oily skin, facial acne |
| Dry skin, cold hands and feet | Click or tap here to enter text. |

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| --- | --- |
| Women | |
| Cycle more than 28 days | Miss some periods |
| Cycle less than 28 days | Menses slow starting with cramps |
| Water retention before menses, hips, breasts | Water retention before menses, feet, hands |
| craves fates, proteins before menses, usually | Craves sweets before menses, usually |
| Sides of breasts tender before menses | Palpitations before menses |
| Menstruation lengthy, frequent cramps | Menstruation short, defined, few cramps |
| Frequent class II pap smears | History of PID, Cervicitis |
| Period early with altitude change | Period late with altitude change |
| Tried, but couldn’t handle birth control pills | Frequent candida/type infections |

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| Men | |
| Frequent cannabis user | Benign prostatic hypertrophy |
| Pain or ache after orgasm | Difficult maintaining erection even in mood |

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| General - Mark mild = x; dominant = xx | |
| Aluminum cooking vessels | Awakens, can’t go to sleep |
| Bad dreams | Blurred vision |
| Brown spots, bronzing of skin | Bruises easily |
| Can’t gain weight | Can’t lose weight |
| Can’t get started without coffee | Chemical or spray poisoning |
| Chronic fatigue, depression | Cry easily without seeming cause |
| Depressed for long periods | Earaches |
| Eat often or else faint/nervous | Eyes often red, inflamed |
| Face, eyes get puffy | Facial twitches |
| Gum problems | Headaches |
| Headaches in mornings, wearing off | Lack of sensation somewhere in body |
| Heart palpitations when hungry | Highly emotional |
| Highly controlled | Impaired hearing |
| Increase in weight (recent) | Likes depressants |
| Likes stimulants | Lower back pain |
| Frequent muscle cramps | Nails split, brittle |
| Nails weak, ridges | Nose bleeds frequently |
| Pollution heavy work/home environment | Weight gain in upper arms, shoulders, neck |
| Ringing in ears | Pulse speeds up after meals |

|  |  |
| --- | --- |
| General (Cont’d) - Mark mild = x; dominant = xx | |
| Sensitive to cold/hot weather | Sensitive to high/low humidity |
| Sexual desire increased/decreased | Stuffy nose during day/evening |
| Tendency seemingly to anemia | Tremors in hands or neck |
| Varicose veins | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Emotional Checklist**

|  |
| --- |
| Emotional Checklist - LG  Put an X next to each statement that corresponds to the way you often feel. Put 2 X’s next to the statement if you “see yourself” in that statement, meaning you recognize those feelings or thoughts often. |
| Anxiety and feeling overwhelmed or stressed, especially anxiety felt in the body, or physical anxiety |
| Feeling worried or fearful |
| Have intrusive thoughts, perseverate or have an overactive brain. Or have unwanted thoughts – thoughts about unpleasant memories, images or worries |
| Panic attacks |
| Unable to relax or loosen up |
| Stiff or tense muscles |
| Feeling stressed and burned-out |
| Craving carbs, alcohol, or drugs for relaxation and calming |

|  |
| --- |
| Emotional Checklist - LT  Put an X next to each statement that corresponds to the way you often feel. Put 2 X’s next to the statement if you “see yourself” in that statement, meaning you recognize those feelings or thoughts often. |
| Anxiety, especially anxiety in the head, ruminating thoughts etc. |
| Panic attacks or phobias |
| Feeling worried or fearful |
| Obsessive thoughts or behaviors |
| Perfectionism or being overly controlling |
| Irritability |
| Anxiety that’s worse in winter |
| Winter blues or seasonal affective disorder |
| Negativity or depression |
| Suicidal thoughts |
| Excessive self-criticism |
|  |
| Emotional Checklist – LT (Cont’d)  Put an X next to each statement that corresponds to the way you often feel. Put 2 X’s next to the statement if you “see yourself” in that statement, meaning you recognize those feelings or thoughts often. |
| Low self-esteem and poor self-confidence |
| PMS or menopausal mood swings |
| Sensitivity to hot weather |
| Hyperactivity |
| Anger or rage |
| Digestive issues |
| Fibromyalgia, temporomandibular joint syndrome, or other pain syndromes |
| Difficulty getting to sleep |
| Insomnia or disturbed sleep |
| Afternoon or evening cravings for carbs, alcohol or drugs |

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| Emotional Checklist - LTY  Put an X next to each statement that corresponds to the way you often feel. Put 2 X’s next to the statement if you “see yourself” in that statement, meaning you recognize those feelings or thoughts often. |
| Depression and apathy |
| Easily bored |
| Lack of energy |
| Lack of focus |
| Lack of drive and low motivation |
| Attention deficit disorder |
| Procrastination and indecisiveness |
| Craving carbs, alcohol, caffeine, or drugs for energy |

|  |
| --- |
| Emotional Checklist - LP  Put an X next to each statement that corresponds to the way you often feel. Put 2 X’s next to the statement if you “see yourself” in that statement, meaning you recognize those feelings or thoughts often. |
| Heightened sensitivity to emotional pain |
| Heightened sensitivity to physical pain |
| Crying or tearing up easily |
| Eating to soothe your mood, or comfort eating |
| Really, really *loving* certain foods, behaviors, drugs, or alcohol |
| Craving a reward or numbing treat |

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| Emotional Checklist - LGL  Put an X next to each statement that corresponds to the way you often feel. Put 2 X’s next to the statement if you “see yourself” in that statement, meaning you recognize those feelings or thoughts often. |
| Crave sugar, starch or alcohol any time during the day |
| Irritable, shaky, headachy – especially if too long between meals |
| Intense cravings for sweets |
| Lightheaded if meals are missed |
| Eating relieves fatigue |
| Agitated, easily upset, nervous |

Additional history with dates or other health related issues you wish to mention:

Click or tap here to enter text.