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Colorado Springs, CO 80907
719-473-9702
833-473-4372
888-473-7172 (Fax)
Clinic@sagewomanherbs.com

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 this Personal Health Profile online form prior to your appointment. If you have a distance appointment, please send it at least one day in advance.

Provide the following by email if appropriate:

☐ Most recent CBC blood work panel and other lab results if relevant to your health issues. ***PLEASE NOTE:*** *Extensive lab reports can be time-consuming to review and can eat up your time with the herbalist. Therefore, she will need to spend additional time reviewing and charting labs. For that reason, more than 8 pages of labs will incur an additional lab review fee of $45.* To avoid this fee, place the pertinent information from each lab test in an excel spread sheet. Or you can simply explain the results from each category of tests in a narrative. (Example: Thyroid tests: On 01/15/18 my TSH was 15. My last TSH test, on 04/01/2020 was 2.4) etc. Please call if you have any additional questions.

☐ If you are having a ZOOM, 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 ZOOM, SKYPE or phone appointment, please fax/email this intake form to us 24 hours in advance of your scheduled appointment.

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.

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.

☐ _____

By placing an "x" in 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.

☐ _____

By placing an "x" in the box above and entering your name, you agree to the Cancellation Policy.

CHILD 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. Weight: Click or tap here to enter text. Height: Click or tap here to enter text. Number and ages of children: 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. Need help setting for a Skype appt?: Click or tap here to enter text.

Full 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**
Eyes, Ears, Nose & Throat		
☐☐☐ Ear aches	☐☐☐ Hearing loss	
☐☐☐ Eye pains	☐☐☐ Excessive ear wax	
☐☐☐ Dry/teary eyes	☐☐☐ Ear infections	
☐☐☐ Runny nose	☐☐☐ Click or tap here to enter text.	

x = sometimes experience	**x x = occurs often**	**x x x = major concern**
Urinary/Kidney		
☐☐☐ Excessive urination	☐☐☐ Dark circles under eyes	
☐☐☐ Water retention	☐☐☐ Click or tap here to enter text.	
☐☐☐ Dark, cloudy urine		

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

x = sometimes experience	**x x = occurs often**	**x x x = major concern**
Respiratory		
☐☐☐ Difficulty breathing	☐☐☐ Flu	
☐☐☐ Cough	☐☐☐ Asthma attacks	
☐☐☐ Sinus congestion	☐☐☐ Post-nasal drip	
☐☐☐ Frequent colds	☐☐☐ Sore throat	
☐☐☐ Colds	☐☐☐ Sinus infections	

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

x = sometimes experience x x = occurs often x x x = major concern	
Other	
☐☐☐ Sensitive to tobacco, chemical odors, perfume	☐☐☐ Tongue coated heavy white/yellow in a.m.
☐☐☐ Dizziness	☐☐☐ Itchiness of skin
☐☐☐ Athlete's foot, jock rash	☐☐☐
☐☐☐ Listlessness	☐☐☐

Allergies		
Does your child 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		
Has your child 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.

Antibiotic and Vaccine Use	
Frequency of antibiotic use: ☐ Once a month to 2 months ☐ Once every 3-6 months ☐ Once every 9-12 months ☐ Twice in their life ☐ Once in their life ☐ Never Click or tap here to enter text.	**Vaccine use:** ☐ Stick strictly to doctor recommended vaccine schedule starting at birth. ☐ Follow a modified vaccine schedule ☐ Have opted out of vaccinating your child ☐ Has your child ever experienced ear infections, fits of screaming, fever or listlessness following a vaccine? Click or tap here to enter text.

NOTE: If your child's healthy history is complex and/or lengthy, please provide a list of dates and health issues here.

Additional history with dates or other health related issues you wish to mention. The text box will expand to fit the narrative:

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.
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.	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.	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.

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.
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.
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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.

Dietary Habits	
☐ Canned Foods	☐ Raw vegetables
☐ Fresh vegetables	☐ Cooked veggies
☐ Red meat/non-organic	☐ Desserts
☐ Red meat/organic or game ☐ Chicken	☐ Fruit juice (Click or tap here to enter text. cups /day)
☐ Agave ☐ Honey ☐ Erythritol ☐ Date sugar	☐ Fruits, canned
☐ Xylitol ☐ Stevia	☐ Fruits, fresh
☐ White/brown sugar ☐ Other sweeteners	☐ Salt (list type)
☐ Sweet and Low, Nutrasweet, Saccharine or chemical sweeteners	☐ Soy/tofu
☐ Soft drinks w/ sugar: Click or tap here to enter text. /day	☐ Tempeh
☐ Soft drinks w/ nutrasweet: Click or tap here to enter text. /day	
☐ Butter ☐ Margarine ☐ Buttery-type spread	☐ Kombucha; quantity per day Click or tap here to enter text.
☐ Olive oil. ☐ Coconut oil ☐ Avocado oil	☐ Kefir or fermented food; quantity per day Click or tap here to enter text.
☐ Canola, Wesson, Vegetable or Soy Oil	
☐ Other Oils? enter type: Click or tap here to enter text.	
☐ Bread; number of slices per day: Click or tap here to enter text. /day Type: Click or tap here to enter text. ☐ Gluten-free breads: Click or tap here to enter text. /day)	☐ Nuts. Quantity is 1 Tablespoon? Click or tap here to enter text. ¼ cup? Click or tap here to enter text. ½ cup? Click or tap here to enter text. More? Click or tap here to enter text.
☐ Crackers; number of crackers per day: Click or tap here to enter text. /day	☐ Paleo breads: Click or tap here to enter text. /day)
Gluten-free crackers: Click or tap here to enter text. /day)	☐ Chips; number of chips per day: Click or tap here to enter text. /day ☐

Does your child drink filtered 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
☐ Thyroid problems	☐ Autism
☐ PANS	☐ PANDAS
☐ Click or tap here to enter text.	☐ Click or tap here to enter text.