

2727 North Tejon Street

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 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.

**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 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.

[ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| A black and white drawing of a plant  Description automatically generated with medium confidenceName: Age: Weight: Height: 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 [ ]  CellZoom Address: Click or tap here to enter text.Full mailing 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: Time:  |
|  |

**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 |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

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

|  |
| --- |
| Practitioner Name(s) |
|  |
|  |
|  |

**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 | [ ] [ ] [ ]  |

|  |
| --- |
| **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 | [ ] [ ] [ ]  |

|  |
| --- |
| **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 | [ ] [ ] [ ]  |

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| --- |
| **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 | [ ] [ ] [ ]  |

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| --- |
| **x = sometimes experience x x = occurs often x x x = major concern** |
| Skin |
| [ ] [ ] [ ]  Boils | [ ] [ ] [ ]  Cysts |
| [ ] [ ] [ ]  Bruises | [ ] [ ] [ ]  Pimples |
| [ ] [ ] [ ]  Dryness | [ ] [ ] [ ]  Sores |
| [ ] [ ] [ ]  Itching | [ ] [ ] [ ]  Broken veins |
| [ ] [ ] [ ]  Varicose veins | [ ] [ ] [ ]  |

|  |
| --- |
| **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 | [ ] [ ] [ ]  |

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| **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 | [ ] [ ] [ ]  |

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| --- |
| **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. |

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| Allergies |
| Do you have allergies? | [ ] No | [ ] Yes, to what?  |
| Medication or herb allergies | [ ] No | [ ] Yes, to what?  |
| Food allergies | [ ] No | [ ] Yes, to what?  |
| History |
| Have you had any operations? | [ ] No | [ ] Yes, list with dates  |
| Any major injuries/accidents? | [ ] No | [ ] Yes, list with dates  |
|  |  |  |

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| 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? |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
| Medications |
| Name of medication | Dosage | Used for what purpose? |
|   |   |   |
|   |   |   |
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| Common Physical Activities |
| [ ]  Sitting at Desk (how long ) | [ ]  Walking |
| [ ]  Sitting in a car (how long ) | [ ]  Yoga |
| [ ]  Standing (how long  | [ ]  Tao Chi |
| [ ] Jogging/running ( 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, explain  |

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| Dietary Habits |
| [ ]  Canned Foods | [ ]  Raw vegetables |
| [ ]  Fresh vegetables | [ ]  Cooked veggies |
| [ ]  Red meat/non-organic | [ ]  Desserts |
| [ ]  Red meat/organic or game | [ ]  Coffee ( cups (not mugs)/day) |
| [ ]  White sugar | [ ]  Black tea ( cups (not mugs)/day) |
| [ ]  Stevia | [ ]  Wine ( cups/day) |
| [ ]  Honey | [ ]  Other alcohol ( cups/day) |
| [ ]  Sweet and Low, nutrasweet, etc | [ ]  Cigarettes: /day |
| [ ]  Soft drinks w/ sugar: /day | [ ]  Salt (list type) |
| [ ]  Soft drinks w/ nutrasweet: /day | [ ]  Soy |
| [ ]  Butter | [ ]  Kombucha; quantity per day  |
| [ ]  Margarine | [ ]  Kefir or fermented food; quantity per day  |
| [ ]  Fruits, fresh | [ ]  Coconut oil |
| [ ]  Fruits, canned | [ ]  Olive Oil |
| [ ]  Canola, Wesson, Vegetable or Soy Oil | [ ]  Other Oils? enter type:  |
| [ ]  Bread; number of slices per day: /dayType:  | [ ]  Nuts. Quantity is 1 Tablespoon? ¼ cup? ½ cup? More?  |
| [ ]  Crackers; number of crackers per day: /day | [ ]  Gluten-free breads: /day) |
| Gluten-free crackers: /day) | [ ]  Chips; number of chips per day: /day [ ]  |

Do you drink filtered water or tap water? [ ]  Filtered [ ]  Tap Type of filter:

If you use a filter, what type and/or conditioner do you use?

If delivered or purchased, is it distilled or reverse osmosis?

How much water do you drink on a regular basis?

**3-Day Diet Journal:**

List a typical day’s meals:

|  |  |  |
| --- | --- | --- |
| Time | Day 1 Food – **Date**  | Beverage(s) |
|   | Breakfast  |   |
|   | Snack  |   |
|   | Lunch  |   |
|   | Snack  |   |
|   | Dinner  |   |
|   | Desserts  |   |

|  |  |  |
| --- | --- | --- |
| Time | Day 2 Food – **Date**  | Beverage(s) |
|   | Breakfast  |   |
|   | Snack  |   |
|   | Lunch  |   |
|   | Snack  |   |
|   | Dinner  |   |
|   | Desserts  |   |

|  |  |  |
| --- | --- | --- |
| Time | Day 3 Food – **Date**  | Beverage(s) |
|   | Breakfast  |   |
|   | Snack  |   |
|   | Lunch  |   |
|   | Snack  |   |
|   | Dinner  |   |
|   | Desserts  |   |

**Family History:**

Check any significant immediate family health history:

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| Family History |
| [ ]  Diabetes | [ ]  Heart conditions |
| [ ]  Asthma | [ ]  Epilepsy |
| [ ]  Cancer | [ ]  Mental illness |
| [ ]  Gout | [ ]  Thyroid problems |
| [ ]   | [ ]   |
| [ ]   | [ ]   |

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

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

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| Constitutional Intake Form*Place a check mark by any symptoms that you currently have or have had in the recent past.*  |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_/\_\_\_/\_\_\_ | File # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **UPPER GI** |  | **RENAL** |  |  |
| \_\_\_ |  | Sometimes nausea in the mornings |  | \_\_\_ |  | Standing too quickly makes pulse roar in ears |  |  |
|  | \_\_\_ | Sometimes nausea in the evenings |  |  | \_\_\_ | Standing too quickly causes faintness, dizziness |  |  |
| \_\_\_ |  | Sometimes excess salivation |  |  | \_\_\_ | Wakes up at night to urinate |  |  |
|  | \_\_\_ | Mouth frequently too dry |  |  | \_\_\_ | Frequent flushing or blushing |  |  |
|  | \_\_\_ | Duodenal ulcer |  |  | \_\_\_ | Water retention with change in weather |  |  |
| \_\_\_ |  | Stomach ulcer |  | \_\_\_ |  | Moderate high blood pressure, crave fats |  |  |
|  | \_\_\_ | Sometimes foul burps |  |  | \_\_\_ | Moderate low blood pressure, craves sweets |  |  |
|  | \_\_\_ | Butterflies in stomach |  |  | \_\_\_ | Frequent thirst |  |  |
|  | \_\_\_ | Seldom eat breakfast |  |  | \_\_\_ | Craving for salt |  |  |
|  | \_\_\_ | Often don’t finish meals |  |  | \_\_\_ | Urine always light colored |  |  |
|  | \_\_\_ | Often eat to calm down |  |  | \_\_\_ | Urine usually darker |  |  |
|  | \_\_\_ | Receding gums |  |  |  |  |  |  |
|  | \_\_\_ | Frequent use of alcohol |  | **LOWER URINARY TRACT** |  |  |
|  | \_\_\_ | Frequent poor appetite |  |  | \_\_\_ | Frequent urination, small amounts |  |  |
| \_\_\_ |  | Strong, demanding hunger |  | \_\_\_ |  | Infrequent urination, copious |  |  |
|  | \_\_\_ | Bitter taste in the morning |  |  | \_\_\_ | Sometimes dribbles urine afterwards |  |  |
|  | \_\_\_ | “Dragon breath” in the morning |  |  | \_\_\_ | Frequent bladder infections |  |  |
|  | \_\_\_ | Acid indigestion at night |  |  | \_\_\_ | Demanding and sudden need to urinate |  |  |
|  | \_\_\_ | Frequent mouth/cold sores |  |  | \_\_\_ | Mucus in urine |  |  |
|  | \_\_\_ | Sometimes difficulty swallowing |  |  | \_\_\_ | Benign prostatic hypertrophy (males) |  |  |
|  | \_\_\_ | Indigestion after eating |  |  | \_\_\_ | Dull ache after urination |  |  |
| **LOWER GI** |  | **REPRODUCTIVE - ALL** |  |  |
| \_\_\_ |  | Stools loose with gas |  | \_\_\_ |  | Sweat freely with strong scent |  |  |
|  | \_\_\_ | Constipation with gas |  | \_\_\_ |  | Oily skin, facial acne |  |  |
|  | \_\_\_ | Frequent constipation |  |  | \_\_\_ | Dry skin, cold hands and feet |  |  |
| \_\_\_ |  | Digestion unusually rapid |  |  |  |  |  |  |
| \_\_\_ |  | Loose stools when tired/stressed |  | **WOMEN** |  |  |
|  | \_\_\_ | Light colored, hard stools |  |  | \_\_\_ | Cycle more than 28 days |  |  |
| \_\_\_ |  | Dark, soft stools |  | \_\_\_ |  | Cycle less than 28 days |  |  |
| \_\_\_ |  | Quick defecation after eating |  | \_\_\_ |  | Water retention before menses, hips, breasts |  |  |
|  | \_\_\_ | Intestines often bloated |  |  | \_\_\_ | Water retention before menses, feet, hands |  |  |
|  | \_\_\_ | Constipation with hemorrhoids |  | \_\_\_ |  | Craves fats, proteins before menses, usually |  |  |
|  | \_\_\_ | " with painful defecation |  |  | \_\_\_ | Craves sweets before menses, usually |  |  |
|  | \_\_\_ | " with hard, marbly stools |  | \_\_\_ |  | Sides of breasts tender before menses |  |  |
|  | \_\_\_ | " with fully formed stools |  |  | \_\_\_ | Miss some periods |  |  |
|  | \_\_\_ | " alternate with diarrhea |  |  | \_\_\_ | Menses slow starting with cramps |  |  |
|  | \_\_\_ | Frequent need for laxatives |  | \_\_\_ |  | Palpitations before menses |  |  |
|  | \_\_\_ | Tongue often coated |  |  | \_\_\_ | Menstruation lengthy, frequent cramps |  |  |
|  |  |  |  | \_\_\_ |  | Menstruation short, defined, few cramps |  |  |
| **LIVER** |  |  | \_\_\_ | Frequent class II Pap Smears |  |  |
|  | \_\_\_ | Dry, even scaly skin |  |  | \_\_\_ | History of PID, cervicitis |  |  |
| \_\_\_ |  | Moist, sometimes oily skin |  |  | \_\_\_ | Miscarriages, problem pregnancy |  |  |
| \_\_\_ |  | Hives from food or drugs |  | \_\_\_ |  | Period early with altitude change |  |  |
|  | \_\_\_ | Hay fever or asthma |  |  | \_\_\_ | Period late with altitude change |  |  |
| \_\_\_ |  | Craves proteins, fats |  |  | \_\_\_ | Tried, but couldn’t handle birth control pills |  |  |
|  | \_\_\_ | Craves fruit or sweets |  |  | \_\_\_ | Frequent candida/type infections |  |  |
|  | \_\_\_ | Frequent trouble digesting fats |  |  |  |  |  |  |
|  | \_\_\_ | Acne on face AND buttocks |  | **MEN** |  |  |
|  | \_\_\_ | Seems to have low blood sugar |  |  | \_\_\_ | Frequent cannabis user |  |  |
|  | \_\_\_ | Had hepatitis in past |  |  | \_\_\_ | Pain or ache after orgasm |  |  |
|  | \_\_\_ | Frequent use of alcohol |  |  | \_\_\_ | Benign prostatic hypertrophy |  |  |
|  | \_\_\_ | Work with solvents |  |  | \_\_\_ | Difficult maintaining erection even in mood |  |  |
|  | \_\_\_ | Psoriasis, eczema, dermatitis |  |  |  |  |  |  |
| **LIVER (cont’d)** | \_\_\_ | Frequent minor illnesses |  |  |  |  |  |  |
| \_\_\_ |  | Fever w/sweat when sick |  |  |  |  |  |  |
|  | \_\_\_ | Don't sweat when sick |  |  |  |  |  |  |

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| --- | --- | --- |
| Constitutional Intake Form |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_/\_\_\_/\_\_\_ | File # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |
| **RESPIRATORY** |  | **GENERAL** |  |  |
|  | \_\_\_ | Shortness of breath when standing/walking |  | Mark conditions that are frequent. If it is mild, |  |  |
|  | \_\_\_ | Tobacco smoker |  | mark "1"; if dominant condition, mark "2". |  |  |
| \_\_\_ |  | Easy coughing of mucus |  | \_\_\_\_\_\_\_\_\_\_\_ | Aluminum cooking vessels |  |  |
|  | \_\_\_ | Difficulty swallowing mucus' |  | \_\_\_\_\_\_\_\_\_\_\_ | Awakens, can't go back to sleep |  |  |
|  | \_\_\_ | Rapid, shallow breather |  | \_\_\_\_\_\_\_\_\_\_\_ | Bad dreams |  |  |
|  | \_\_\_ | Sometimes wake up choking/gasping for breath |  | \_\_\_\_\_\_\_\_\_\_\_ | Blurred vision |  |  |
|  | \_\_\_ | Yawns frequently |  | \_\_\_\_\_\_\_\_\_\_\_ | Brown spots, bronzing of skin |  |  |
| \_\_\_ |  | Sometimes hyperventilates |  | \_\_\_\_\_\_\_\_\_\_\_ | Bruises easily |  |  |
|  | \_\_\_ | Frequent chest colds |  | \_\_\_\_\_\_\_\_\_\_\_ | Can't gain weight |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Can't lose weight |  |  |
| **CARDIOVASCULAR** |  | \_\_\_\_\_\_\_\_\_\_\_ | Can't get started without coffee |  |  |
| \_\_\_ |  | Slow, strong pulse |  | \_\_\_\_\_\_\_\_\_\_\_ | Chemical or spray poisoning |  |  |
|  | \_\_\_ | Fast, light pulse |  | \_\_\_\_\_\_\_\_\_\_\_ | Chronic fatigue, depression |  |  |
| \_\_\_ |  | Frequent physical activity |  | \_\_\_\_\_\_\_\_\_\_\_ | Cry easily without seeming cause |  |  |
| \_\_\_ |  | Warm bodied |  | \_\_\_\_\_\_\_\_\_\_\_ | Depressed for long periods |  |  |
|   | \_\_\_ | Cold bodied |  | \_\_\_\_\_\_\_\_\_\_\_ | Earaches |  |  |
|  | \_\_\_ | Sometimes dizzy or faint |  | \_\_\_\_\_\_\_\_\_\_\_ | Eat often or else faint/nervous |  |  |
| \_\_\_ |  | Hands warm, sweaty |  | \_\_\_\_\_\_\_\_\_\_\_ | Eyes often red, inflamed |  |  |
|  | \_\_\_ | Hands cold, clammy or dry |  | \_\_\_\_\_\_\_\_\_\_\_ | Face, eyes get puffy |  |  |
| \_\_\_ |  | Palpitations either as an adolescent or before menses |  | \_\_\_\_\_\_\_\_\_\_\_ | Facial twitches |  |  |
| \_\_\_ |  | Hypertension, responds to diuretics |  | \_\_\_\_\_\_\_\_\_\_\_ | Gum problems |  |  |
|  | \_\_\_ | Hypertension, not responding to diuretic |  | \_\_\_\_\_\_\_\_\_\_\_ | Headaches |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Headaches in morning, wearing off |  |  |
| **LYMPHATIC** |  | \_\_\_\_\_\_\_\_\_\_\_ | Heart palpitations when hungry |  |  |
| \_\_\_ |  | Recuperates quickly if ill |  | \_\_\_\_\_\_\_\_\_\_\_ | Heart palpitations after eating |  |  |
|  | \_\_\_ | Recuperates slowly if ill |  | \_\_\_\_\_\_\_\_\_\_\_ | Highly emotional |  |  |
| \_\_\_ |  | Injuries heal quickly |  | \_\_\_\_\_\_\_\_\_\_\_ | Highly controlled |  |  |
|  | \_\_\_ | Injuries heal slowly |  | \_\_\_\_\_\_\_\_\_\_\_ | Impaired hearing |  |  |
|  | \_\_\_ | Eczema, dermatitis |  | \_\_\_\_\_\_\_\_\_\_\_ | Increase in weight (recent) |  |  |
|  | \_\_\_ | Asthma or hay fever |  | \_\_\_\_\_\_\_\_\_\_\_ | Lack of sensation somewhere in the body |  |  |
|  | \_\_\_ | Arthritis or rheumatism |  | \_\_\_\_\_\_\_\_\_\_\_ | Likes depressants |  |  |
| \_\_\_ |  | Digests fats easily |  | \_\_\_\_\_\_\_\_\_\_\_ | Likes stimulants |  |  |
|  | \_\_\_ | Digests fats poorly |  | \_\_\_\_\_\_\_\_\_\_\_ | Lower back pain |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Frequent muscle cramps |  |  |
| **SKIN** |  | \_\_\_\_\_\_\_\_\_\_\_ | Nails split, brittle |  |  |
| \_\_\_ |  | Skin eruptions superficial, come to a head |  | \_\_\_\_\_\_\_\_\_\_\_ | Nails weak, ridges |  |  |
|  | \_\_\_ | Skin eruptions deep, not coming to a head |  | \_\_\_\_\_\_\_\_\_\_\_ | Nose bleeds frequently |  |  |
|  | \_\_\_ | Skin on trunk is dry |  | \_\_\_\_\_\_\_\_\_\_\_ | Pollution heavy in work or home environment |  |  |
| \_\_\_ |  | Oily scalp or hair |  | \_\_\_\_\_\_\_\_\_\_\_ | Ringing in ears |  |  |
|  | \_\_\_ | Dry scalp or hair |  | \_\_\_\_\_\_\_\_\_\_\_ | Pulse speeds up after meals |  |  |
|  | \_\_\_ | Cracks, fissures on heel, feet, slow healing  |  | \_\_\_\_\_\_\_\_\_\_\_ | Sensitive to cold weather |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Sensitive to hot weather |  |  |
| **MUCUS** |  | \_\_\_\_\_\_\_\_\_\_\_ | Sensitive to high humidity |  |  |
|  | \_\_\_ | Sores, cracks, on mouth, anus, vagina |  | \_\_\_\_\_\_\_\_\_\_\_ | Sensitive to low humidity |  |  |
|  | \_\_\_ | Lips are often dry, chapped |  | \_\_\_\_\_\_\_\_\_\_\_ | Sexual desire decreased |  |  |
|  | \_\_\_ | Food often causes intestinal pain passing through |  | \_\_\_\_\_\_\_\_\_\_\_ | Sexual desire increased |  |  |
|  | \_\_\_ | Gets some throat easily |  | \_\_\_\_\_\_\_\_\_\_\_ | Stuffy nose during the day |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Stuffy nose in evening, night |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Tendency, seemingly to anemia |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Tremors in hands or neck |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Varicose veins |  |  |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_ | Weight gain in upper arms, shoulders, back of neck |  |  |

**Emotional Checklist**

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| Emotional Checklist - GPut 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 |

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| Emotional Checklist – L-TPut 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 |
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| 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 – L-TyPut 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 |

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| Emotional Checklist – L-PhPut 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 – L-GLPut 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: