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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.

PERSONAL HEALTH PROFILE

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

Name: Age: Weight: Height: Number and ages of children:

Phone #: (HOME) (CELL)
Preference: ☐ Home ☐ Cell

Zoom Address:

Full mailing address:

E-mail Address: Referred by:

Date of Initial Appointment: 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	☐☐☐

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	☐☐☐

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	☐☐☐

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	☐☐☐

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?
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

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 *(if you have more medications than will fit on this form, please email a separate page)*		
Name of medication	Dosage	Used for what purpose?

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

Dietary Habits	
☐ Canned Foods	☐ Raw vegetables
☐ Fresh vegetables	☐ Cooked veggies
☐ Red meat/non-organic	☐ Desserts
☐ Red meat/organic or game ☐ Chicken	☐ Coffee (cups (not mugs)/day)
☐ Agave ☐ Honey ☐ Erythritol ☐ Date sugar	☐ Black tea (cups (not mugs)/day)
☐ Xylitol ☐ Stevia	☐ Wine (cups/day)
☐ White/brown sugar ☐ Other sweeteners	☐ Other alcohol (cups/day)
☐ Sweet and Low, Nutrasweet, Saccharine or chemical sweeteners	☐ Cigarettes: /day
☐ Soft drinks w/ sugar: /day	☐ Salt (list type)
☐ Soft drinks w/ nutrasweet: /day	☐ Soy/tofu ☐ Tempeh
☐ 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.
☐ Fruits, fresh	☐ Coconut oil
☐ Fruits, canned	☐ Olive Oil
☐ Canola, Wesson, Vegetable or Soy Oil	☐ Other Oils? enter type: Click or tap here to enter text.
☐ Bread; number of slices per day: /day Type: ☐ Gluten-free breads: /day)	☐ Nuts. Quantity is 1 Tablespoon? ¼ cup? ½ cup? More?
☐ Crackers; number of crackers per day: /day	☐ Paleo 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:

Family History	
☐ Diabetes	☐ Heart conditions
☐ Asthma	☐ Epilepsy
☐ Cancer	☐ Mental illness
☐ Gout	☐ Thyroid problems
☐	☐
☐	☐

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	☐ 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

Constitutional Intake Form

Place a check mark by any symptoms that you currently have or have had in the recent past.

UPPER GI

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

LOWER GI

___ Stools loose with gas
___ Constipation with gas
___ Frequent constipation
___ Digestion unusually rapid
___ Loose stools when tired/stressed
___ Light colored, hard stools
___ Dark, soft stools
___ Quick defecation after eating
___ Intestines often bloated
___ Constipation with hemorrhoids
___ " with painful defecation
___ " with hard, marbly stools
___ " with fully formed stools
___ " alternate with diarrhea
___ Frequent need for laxatives
___ Tongue often coated

LIVER

___ Dry, even scaly skin
___ Moist, sometimes oily skin
___ Hives from food or drugs
___ Hay fever or asthma
___ Craves proteins, fats
___ Craves fruit or sweets
___ Frequent trouble digesting fats
___ Acne on face AND buttocks
___ Seems to have low blood sugar
___ Had hepatitis in past
___ Frequent use of alcohol
___ Work with solvents
___ Psoriasis, eczema, dermatitis
___ Frequent minor illnesses

RENAL

___ Standing too quickly makes pulse roar in ears
___ Standing too quickly causes faintness, 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
___ Frequent thirst
___ Craving for salt
___ Urine always light colored
___ Urine usually darker

LOWER URINARY TRACT

___ Frequent urination, small amounts
___ Infrequent urination, copious
___ Sometimes dribbles urine afterwards
___ Frequent bladder infections
___ Demanding and sudden need to urinate
___ Mucus in urine
___ Benign prostatic hypertrophy (males)
___ Dull ache after urination

REPRODUCTIVE - ALL

___ Sweat freely with strong scent
___ Oily skin, facial acne
___ Dry skin, cold hands and feet

WOMEN

___ Cycle more than 28 days
___ Cycle less than 28 days
___ Water retention before menses, hips, breasts
___ Water retention before menses, feet, hands
___ Craves fats, proteins before menses, usually
___ Craves sweets before menses, usually
___ Sides of breasts tender before menses
___ Miss some periods
___ Menses slow starting with cramps
___ Palpitations before menses
___ Menstruation lengthy, frequent cramps
___ Menstruation short, defined, few cramps
___ Frequent class II Pap Smears
___ History of PID, cervicitis
___ Miscarriages, problem pregnancy
___ Period early with altitude change
___ Period late with altitude change
___ Tried, but couldn't handle birth control pills
___ Frequent candida/type infections

MEN

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

LIVER (cont'd)

___ Fever w/sweat when sick
___ Don't sweat when sick

RESPIRATORY

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

CARDIOVASCULAR

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

LYMPHATIC

___ Recuperates quickly if ill
___ Recuperates slowly if ill
___ Injuries heal quickly
___ Injuries heal slowly
___ Eczema, dermatitis
___ Asthma or hay fever
___ Arthritis or rheumatism
___ Digests fats easily
___ Digests fats poorly

SKIN

___ Skin eruptions superficial, come to a head
___ Skin eruptions deep, not coming to a head
___ Skin on trunk is dry
___ Oily scalp or hair
___ Dry scalp or hair
___ Cracks, fissures on heel, feet, slow healing

MUCUS

___ Sores, cracks, on mouth, anus, vagina
___ Lips are often dry, chapped
___ Food often causes intestinal pain passing through
___ Gets some throat easily

GENERAL

Mark conditions that are frequent. If it is mild, mark "1"; if dominant condition, mark "2".

___ Aluminum cooking vessels
___ Awakens, can't go back 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 morning, wearing off
___ Heart palpitations when hungry
___ Heart palpitations after eating
___ Highly emotional
___ Highly controlled
___ Impaired hearing
___ Increase in weight (recent)
___ Lack of sensation somewhere in the body
___ Likes depressants
___ Likes stimulants
___ Lower back pain
___ Frequent muscle cramps
___ Nails split, brittle
___ Nails weak, ridges
___ Nose bleeds frequently
___ Pollution heavy in work or home environment
___ Ringing in ears
___ Pulse speeds up after meals
___ Sensitive to cold weather
___ Sensitive to hot weather
___ Sensitive to high humidity
___ Sensitive to low humidity
___ Sexual desire decreased
___ Sexual desire increased
___ 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

Emotional Checklist - G
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 – L-T
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
☐ ☐ 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

Emotional Checklist – L-Ty
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 – L-Ph
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

Emotional Checklist – L-GL
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: