



2727 North Tejon Street
Colorado Springs, CO 80907
719-473-9702
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, or phone appointment, please fax/email this intake form to us 24 hours in advance of your scheduled appointment.



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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 or email. Call our dispensary direct at 719-473-9702 or email at clinic@sagewomanherbs.com.



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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.



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PERSONAL HEALTH PROFILE

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



Name: _____ Age: _____ Weight: _____
 Height: _____ Ages of children: _____

Choose one:

- I would prefer this appointment to be in person (available on Tuesdays in Colorado Springs)
 - I prefer this appointment to be via zoom (available Tuesdays, Wednesdays and Thursdays)
 - I prefer this appointment to be by phone. (available Tuesdays, Wednesdays and Thursdays).
- Please call me at this telephone #: _____

Other phone numbers you may reach me at: _____

Full mailing address where I would like herbs and supplements shipped:

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



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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		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Previous stroke(s)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold hands/feet
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain upper left chest		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tingling arms/hands
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High cholesterol
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling ankles/joints		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor cholesterol ratios
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Palpitations		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____

Muscles/Joints	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Backache upper/lower	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Broken bones past/present	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stiffness in joints
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____

Eyes, Ears, Nose & Throat	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear aches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hearing loss
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pains, dry/teary	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive ear wax
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing/worsening vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____

Urinary/Kidney	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Up to urinate 1x night
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Water retention	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Up to urinate 2x's night
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney stones past/present	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning urination
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lower back stiffness/soreness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dark, cloudy urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dark circles under eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____

Skin	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cysts
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruises	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pimples
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rash	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sores
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry skin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Oily skin



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Respiratory	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infections
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma attacks
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus congestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Post-nasal drip
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____

Antibiotic History	
Antibiotics in past year: 1 <input type="checkbox"/> 2 or more <input type="checkbox"/>	Antibiotics in past 3 years: 1 <input type="checkbox"/> 2 or more <input type="checkbox"/>
Antibiotics as a child: 1 <input type="checkbox"/> 2 or more <input type="checkbox"/>	Antibiotics as a child: too many to count <input type="checkbox"/>

x = sometimes experience	x x = occurs often	x x x = major concern
Gastrointestinal		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Indigestion	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 bowel movement/day	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 bm/day	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis B	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 bm/every other day	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallstones	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 or less bm/week	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in stools	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Light colored stools	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal cramps	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Black, tarry stools	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning esophagus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent diarrhea	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> hemorrhoids	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SIBO: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> IBS: _____	

x = sometimes experience	x x = occurs often	x x x = major concern
Other		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Memory problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Uncomfortable in moldy, damp rooms	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness w vision issues	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Toenail fungus	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crave sweets, breads or alcohol	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitive to tobacco, chemical odors, perfume	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Athlete's foot, jock rash	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tongue coated heavy white/yellow in a.m.	

Allergies		
Do you have allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, to what? _____
Medication or herb allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes, to what? _____
Food allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes, to what? _____



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Medications		
Name of medication	Dosage	Used for what purpose?

Common Physical Activities		
<input type="checkbox"/> Sitting at Desk (how long _____)	<input type="checkbox"/> Walking	
<input type="checkbox"/> Sitting in a car (how long _____)	<input type="checkbox"/> Yoga	
<input type="checkbox"/> Standing (how long _____)	<input type="checkbox"/> Tao Chi	
<input type="checkbox"/> Jogging/running (_____ times per week)	<input type="checkbox"/> Hiking	
<input type="checkbox"/> Aerobics	<input type="checkbox"/> Bike riding	
<input type="checkbox"/> Swimming	<input type="checkbox"/> Horseback riding	
<input type="checkbox"/> Weight-lifting	<input type="checkbox"/> Tennis	
Do any of the above activities aggravate a current health condition?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain _____



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Dietary Habits	
<input type="checkbox"/> Canned Foods	<input type="checkbox"/> Raw vegetables
<input type="checkbox"/> Fresh vegetables	<input type="checkbox"/> Cooked veggies
<input type="checkbox"/> Red meat/non-organic	<input type="checkbox"/> Desserts
<input type="checkbox"/> Red meat/organic or game <input type="checkbox"/> Chicken	<input type="checkbox"/> Coffee (_____ cups (not mugs) /day)
<input type="checkbox"/> Agave <input type="checkbox"/> Honey <input type="checkbox"/> Erythritol <input type="checkbox"/> Date sugar	<input type="checkbox"/> Black tea (_____ cups (not mugs) /day)
<input type="checkbox"/> Xylitol <input type="checkbox"/> Stevia	<input type="checkbox"/> Wine (_____ cups/day)
<input type="checkbox"/> White/brown sugar <input type="checkbox"/> Other sweeteners	<input type="checkbox"/> Other alcohol (_____ cups/day)
<input type="checkbox"/> Sweet and Low, Nutrasweet, Saccharine or chemical sweeteners	<input type="checkbox"/> Cigarettes: _____ /day
<input type="checkbox"/> Soft drinks w/ sugar: _____ /day	<input type="checkbox"/> Salt (list type)
<input type="checkbox"/> Soft drinks w/ nutrasweet: _____ /day	<input type="checkbox"/> Soy/tofu <input type="checkbox"/> Tempeh
<input type="checkbox"/> Butter <input type="checkbox"/> Margarine <input type="checkbox"/> Buttery-type spread	<input type="checkbox"/> Kombucha; quantity per day _____
<input type="checkbox"/> Extra virgin olive oil. <input type="checkbox"/> Coconut oil <input type="checkbox"/> Avocado, Canola, Wesson, Vegetable or Soy Oil	<input type="checkbox"/> Kefir or fermented food; quantity per day _____
<input type="checkbox"/> Other Oils? enter type: _____	<input type="checkbox"/> Fruits, fresh <input type="checkbox"/> Fruits, canned
<input type="checkbox"/> Bread; number of slices per day: _____ /day Type: _____ <input type="checkbox"/> Gluten-free breads: _____ /day)	<input type="checkbox"/> Nuts. Quantity is 1 Tablespoon? _____ ¼ cup? _____ ½ cup? _____ More? _____
<input type="checkbox"/> Crackers; number of crackers: _____ /day Gluten-free crackers: _____ /day)	<input type="checkbox"/> Paleo breads: _____ /day)
	<input type="checkbox"/> Chips; number of chips _____ /day <input type="checkbox"/>

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? _____



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3-Day Diet Journal:

List a typical day's meals:

Time	Day 1 Food – Date	Beverage(s)
	Breakfast _____ _____	
	Snack _____ _____	
	Lunch _____ _____	
	Snack _____ _____	
	Dinner _____ _____	
	Desserts _____ _____	



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Time	Day 2 Food – Date	Beverage(s)
	Breakfast _____ _____	
	Snack _____ _____	
	Lunch _____ _____	
	Snack _____ _____	
	Dinner _____ _____	
	Desserts _____ _____	



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Time	Day 3 Food – Date	Beverage(s)
	Breakfast _____ _____	
	Snack _____ _____	
	Lunch _____ _____	
	Snack _____ _____	
	Dinner _____ _____	
	Desserts _____ _____	



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Family History:

Check any significant immediate family health history:

Family History	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart conditions
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Gout	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____

For Men Only	
<input type="checkbox"/> Frequency of urination	<input type="checkbox"/> Swollen prostate
<input type="checkbox"/> Hesitancy when urinating	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Difficulty getting/maintain erection	<input type="checkbox"/> Benign Prostatic Hyperplasia

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

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, marbled 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

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, craves 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



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Constitutional Intake Form continued:

- Psoriasis, eczema, dermatitis
- Frequent minor illnesses
- 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



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Constitutional Intake Form continued:

- _____ Tendency, seemingly to anemia
- _____ Tremors in hands or neck
- _____ Varicose veins
- _____ Weight gain in upper arms, shoulders, back of neck

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.
<input type="checkbox"/> <input type="checkbox"/> Anxiety and feeling overwhelmed or stressed, especially anxiety felt in the body, or physical anxiety
<input type="checkbox"/> <input type="checkbox"/> Feeling worried or fearful
<input type="checkbox"/> <input type="checkbox"/> Have intrusive thoughts, have an overactive brain, or have unwanted thoughts – especially thoughts about unpleasant memories, images or worries
<input type="checkbox"/> <input type="checkbox"/> Panic attacks
<input type="checkbox"/> <input type="checkbox"/> Unable to relax or loosen up
<input type="checkbox"/> <input type="checkbox"/> Stiff or tense muscles
<input type="checkbox"/> <input type="checkbox"/> Feeling stressed and burned-out
<input type="checkbox"/> <input type="checkbox"/> 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.
<input type="checkbox"/> <input type="checkbox"/> Anxiety, especially anxiety in the head, ruminating thoughts etc.
<input type="checkbox"/> <input type="checkbox"/> Panic attacks or phobias
<input type="checkbox"/> <input type="checkbox"/> Feeling worried or fearful
<input type="checkbox"/> <input type="checkbox"/> Obsessive thoughts or behaviors
<input type="checkbox"/> <input type="checkbox"/> Perfectionism or being overly controlling
<input type="checkbox"/> <input type="checkbox"/> Irritability
<input type="checkbox"/> <input type="checkbox"/> Anxiety that's worse in winter
<input type="checkbox"/> <input type="checkbox"/> Winter blues or seasonal affective disorder
<input type="checkbox"/> <input type="checkbox"/> Negativity or depression
<input type="checkbox"/> <input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> <input type="checkbox"/> Excessive self-criticism
<input type="checkbox"/> <input type="checkbox"/> Low self-esteem and poor self-confidence
<input type="checkbox"/> <input type="checkbox"/> PMS or menopausal mood swings
<input type="checkbox"/> <input type="checkbox"/> Sensitivity to hot weather
<input type="checkbox"/> <input type="checkbox"/> Hyperactivity
<input type="checkbox"/> <input type="checkbox"/> Anger or rage



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<input type="checkbox"/> <input type="checkbox"/> Digestive issues
<input type="checkbox"/> <input type="checkbox"/> Fibromyalgia, temporomandibular joint syndrome, or other pain syndromes
<input type="checkbox"/> <input type="checkbox"/> Difficulty getting to sleep
<input type="checkbox"/> <input type="checkbox"/> Insomnia or disturbed sleep
<input type="checkbox"/> <input type="checkbox"/> 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.
<input type="checkbox"/> <input type="checkbox"/> Depression and apathy
<input type="checkbox"/> <input type="checkbox"/> Easily bored
<input type="checkbox"/> <input type="checkbox"/> Lack of energy
<input type="checkbox"/> <input type="checkbox"/> Lack of focus
<input type="checkbox"/> <input type="checkbox"/> Lack of drive and low motivation
<input type="checkbox"/> <input type="checkbox"/> Attention deficit disorder
<input type="checkbox"/> <input type="checkbox"/> Procrastination and indecisiveness
<input type="checkbox"/> <input type="checkbox"/> 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.
<input type="checkbox"/> <input type="checkbox"/> Heightened sensitivity to emotional pain
<input type="checkbox"/> <input type="checkbox"/> Heightened sensitivity to physical pain
<input type="checkbox"/> <input type="checkbox"/> Crying or tearing up easily
<input type="checkbox"/> <input type="checkbox"/> Eating to soothe your mood, or comfort eating
<input type="checkbox"/> <input type="checkbox"/> Really, really <i>loving</i> certain foods, behaviors, drugs, or alcohol
<input type="checkbox"/> <input type="checkbox"/> 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.
<input type="checkbox"/> <input type="checkbox"/> Crave sugar, starch or alcohol any time during the day
<input type="checkbox"/> <input type="checkbox"/> Irritable, shaky, headachy – especially if too long between meals
<input type="checkbox"/> <input type="checkbox"/> Intense cravings for sweets
<input type="checkbox"/> <input type="checkbox"/> Lightheaded if meals are missed
<input type="checkbox"/> <input type="checkbox"/> Eating relieves fatigue
<input type="checkbox"/> <input type="checkbox"/> Agitated, easily upset, nervous

