Personal Heath Evaluation

I. Personal Information

Name_____ Date _____
Age _____ Height_____ Weight _____
Assigned Sex _____ Preferred Pronouns (she/he/they etc.) _____
Relationship Status _____ First Language _____
Phone/Skype Number _____
Faith/Religion/Spirituality: _____
How do you learn best (visual, auditory, written, etc.)? _____
Names and ages of children: _____
_____

II. Diet, Nutrition, and General Health

How often do you consume the following? (N = never S = sometimes O = often)					
Raw Foods		Milk		Fresh Fruits	
White Flour		Pork/Shellfish		Vegetables	
Alcohol		Red Meat		Green Salads	
Fried Foods		Chicken/Turkey		Whole Grains	
Caffeine		Artificial Sweeteners		Fresh Fish	
Sodas		Soy (tofu, tempeh etc.)		Sweets/Refined Sugar	
Nuts		Fermented Foods		Chips	
Cheese		Yogurt		Protein Supplements	
Butter	____	Oils (coconut, olive, etc.)	____		____

How much water do you drink/day? _____ cups

Which foods do you crave?

What foods do you feel you would not want to do without?

How often do you exercise? _____ hours per _____

What do you do for exercise?

Do you sweat **rarely** **appropriately** **too much**? (Circle One)

Do you smoke tobacco? _____ If so, how many cigarettes per day? _____

Have you ever smoked in the past? _____ For how many years? _____

When did you quit? _____

How many hours of sleep on average do you get each night? _____ hours
Do you dream? _____ Do you remember your dreams? _____

What is your energy level like? No energy (0 1 2 3 4 5 6 7 8 9 10) High energy

How often do you eliminate your bowels?
_____/day _____/week

Circle one:
Are you more "**hot natured**" or "**cold natured**"? Are you more comfortable in **summer** or **winter**?
Are you the first person to cover up with layers? **Yes** **No**

What is your stress level? No stress (0 1 2 3 4 5 6 7 8 9 10) High stress

What nutritional supplements are you currently taking? Attach separate sheet if necessary.

What current health concerns are you seeking help for? Please indicate when these began, if possible.

Female bodied only:
Are you pregnant or nursing?

Menstruation: Cycle length _____ Bleed length _____

Birth Control _____

III. Medical Information

Are you under a physician's care for a condition? _____

If yes, what are you being treated for?

List any other practitioners (physicians, massage therapists, chiropractors, herbalists, etc.) who you are seeing:

List all medications you are currently taking and what they are taken for (including aspirin, antacids, etc.), indicating if they are over the counter (OTC) or prescription (P). Attach separate sheet if necessary.

Name of Product/Used for	OTC or P?	Dosage + Frequency (#/day)

List any serious illnesses or surgeries you have had in the past:

Allergies (include type of reaction)	
Medications	
Foods	
Environmental	

Have you been diagnosed by a licensed physician with any of the following? Check all that apply.

❑ AIDS
❑ Angina
❑ Anxiety
❑ Arthritis (Rheumatoid)
❑ Arthritis (Osteo-)
❑ Arrhythmia (irregular heart beat)
❑ Asthma
❑ Attention Deficit Disorder (ADD/ADHD)
❑ Autoimmune Disorders, Specify:

❑ Benign Prostatic Hyperplasia (BPH)
❑ Bipolar Mood Disorder (Manic Depressive Disorder)
❑ Bleeding Disorders
❑ Cancer, Specify type:

❑ Cardiac Arrest (Heart Attack)
❑ Celiac Disease
❑ Chronic Obstructive Pulmonary Disorder (COPD)
❑ Cirrhosis of the Liver
❑ Colitis
❑ Congestive Heart Failure
❑ Depression
❑ Diabetes
❑ Eczema
❑ Endometriosis
❑ Epilepsy
❑ Fatty Liver Disease
❑ Fibromyalgia
❑ Grave's Disease (Hyperthyroid)

❑ Hahsimoto's Disease (Thyroiditis)
❑ Hepatitis
❑ High Blood Pressure (Hypertension)
❑ Irritable Bowel Disorder (Crohn's or Colitis)
❑ Kidney Stones
❑ Low Thyroid (Hypothyroid)
❑ Lupus
❑ Multiple Sclerosis
❑ Obsessive-Compulsive Disorder ❑ Osteoporosis
❑ Psoriasis
❑ Ulcers

Other, specify:

IV. Personal History

What is your occupation?

Do you like your job?

Is it stressful physically or mentally?

Do you work with a lot of chemicals or pollutants?

How many people live in your household? _____
Are you happy with your living arrangements? Circle: **Yes** **No** If no, please explain:

What are some of your interests/hobbies/passions?

If you are comfortable, please indicate approximate dates and describe the nature of any traumatic experiences that you think are relevant to your health or state of being (e.g. divorce, loss of relationship, loss of job, diagnosis, injury, incarceration, death, family illness, etc.):

Year Event

_____
_____
_____
_____
_____
_____

Family Medical History:

Mother:

Father:

Siblings:

Grandparents:

Do you feel supported? If so, who is in your support system?

What are the two emotions you experience most often (anger, irritability, sadness, worry, hopelessness, grief, fear, joy, happiness, etc.)?

Any additional comments which may or may not pertain to your present health (odd symptoms, emotions, etc.)?

V. Symptom Checklist

Eyes, Ears, Nose & Throat
___ Eye pain, wet/dry
___ Failing vision
___ Earaches
___ Hearing loss
___ Ringing in the ears (tinnitus)
___ Hay Fever
___ Tonsils
___ Feeling of something stuck in throat
___ Other: _____

Digestive
___ Mouth ulcers
___ Halitosis (bad breath)
___ Hiatal hernia
___ Bloating
___ History of hepatitis
___ Gall Stones
___ Hypoglycemia (low blood sugar)
___ Indigestion
___ Ulcers
___ Constipation
___ Diarrhea
___ Irritable Bowel Syndrome
___ Polyps
___ Hemorrhoids
___ Bleeding from anus
___ Other: _____

Circulatory
___ High Blood Pressure
___ Low Blood Pressure
___ Palpitations
___ High Cholesterol
___ Triglycerides
___ Varicose veins
___ Spider veins
___ Cold hands and feet
___ Poor circulation
___ Pain in chest
___ Previous Heart Attack/ Stroke
___ Swelling in ankles/joints
___ Other: _____

Respiratory
___ Allergies
___ Asthma
___ Sore throat
___ Sinusitis
___ Post nasal drip
___ Lung congestion
___ Cough
___ History of tuberculosis
___ Recurrent influenza
___ Colds
___ Other: _____

Skin
___ Boils
___ Acne
___ Eczema
___ Psoriasis
___ Bruise easily
___ Herpes Simplex
___ Slow wound healing
___ Other: _____

Musculoskeletal
___ Difficulty breathing
___ Stiffness
___ Bursitis
___ Torn ligaments
___ Backache: upper/lower
___ Broken bones, list: _____
___ Arthritis
___ Mobility restriction
___ Gout
___ Sprains
___ Other: _____

Urinary
___ Bladder infections (cystitis)
___ Kidney Stones
___ Water retention/swelling of ankles/legs

___ Incontinence
___ Painful urination
___ Excessive urination
___ Lower back pain
___ Dark circles under the eyes
___ Gout
___ Other: _____

Endocrine Glands

___ Pituitary
___ Pineal
___ Thyroid
___ Hypothyroid
___ Hyperthyroid
___ Pancreas
___ Diabetes (Circle: **type 1 type 2**)
___ Hypoglycemia
___ Other: _____

Lymphatic

___ Congestion
___ Swollen glands
___ Infection
___ Drainage
___ Other: _____

Nervous System

___ Anxiety
___ Irritability
___ Stress
___ Headaches
___ Migraines
___ Insomnia

Reproductive (Female Bodied)

___ Pregnancies, date(s): _____

___ Miscarriage, date(s): _____

___ Abortion, date(s): _____

___ Contraceptive Use: List type(s) & how long used: _____

Sexually Transmitted Infection, List type if known: _____

Hysterectomy, Date: _____ Reason: _____
___ Uterine fibroids
___ Ovarian cyst
___ Endometriosis
___ Vaginal infection
___ Breast pain

___ Depression
___ Attention Deficit
___ Hyperactivity
___ Mental sluggishness
___ Irritation to strong light
___ Shingles
___ Other: _____

Immune System

___ Autoimmune disease
___ Chronic Fatigue Syndrome
___ Fibromyalgia
___ Neuralgia
___ Frequent colds
___ Vaccination reactions
___ Other: _____

Reproductive (Male Bodied)

___ Impotence
___ Sexually Transmitted Infection
List type if known: _____
___ Prostatitis
___ Difficulty with urination
___ Benign Prostatic Enlargement
___ Premature Ejaculation
___ Lack of sex drive
___ Low Sperm count
___ Low Sperm motility
___ Other: _____

___ Breast lump
___ Pelvic Inflammatory Disease
___ Genital Herpes
___ Cervical dysplasia
___ Painful intercourse
___ Anemia
___ Vaginal itching/discharge
___ Infertility

Menstruation

___ Irregular menstrual cycles
___ Heavy menstrual bleeding
___ Painful menstrual cramps
___ Bleeding between cycles
___ Absence of menstrual cycles
___ Dramatic mood swings around menstrual cycle
___ Lack of sex drive
___ Other: _____

Menopause

___ Hot flashes
___ Dramatic mood swings
___ Dry vaginal lining
___ Osteoporosis
___ Vaginal Bleeding
___ Estrogen Replacement Therapy
___ Lack of sex drive
___ Other: _____

Client Statement

I understand that during this consult I will be offered information about herbs as a guide to general good health and this is for educational purposes only.

Only a physician can diagnose and treat disease. Sydney Batson is not a physician and therefore does not diagnose, treat, or prescribe remedies for disease. The services provided by Sydney Batson are at all times restricted to consultation on the subject of herbalism. I fully understand that Sydney Batson is not a medical doctor and I am not seeking medical diagnostics or treatment procedures from her.

Although rare and usually minor, certain side effects, including allergic reaction, can sometimes occur from natural remedies. I understand that it is my responsibility to discuss any and all information provided during this consultation with my primary health care provider or any other health care providers/specialists whose care I may be under.

Due to HIPPA privacy regulations, your information will be held confidential and not shared with anyone.

Please sign below indicating that you have read and understood the above statement.

Printed Name: _____

Signature: _____

Date: _____