*Synergy Herbal Works*

***Health Questionnaire: Self-Assessment Form***

*Sherri Stickler, Consulting Herbalist \*\* Phone 931-510-5201 \*\*www.synergyherbalworks.com \*\* 250 W. 5th Street Cookeville, TN*

|  |
| --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_ Age: \_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code:\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gender: M F Height: \_\_\_\_ Weight: \_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Children: \_\_\_\_\_\_\_\_  Date of last Physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Main Reason for visit (diagnoses, main complaints and symptoms)?

**Practitioners**

Are you currently under the care of a health care practitioner?

Please note which of the following types of health care practitioners you have seen.

\_\_\_\_Ayurvedic practitioner \_\_\_\_Chiropractor \_\_\_\_Counseling \_\_\_\_Herbalist \_\_\_\_Homeopath \_\_\_\_Naturopath \_\_\_\_Social Worker \_\_\_\_Massage therapist \_\_\_\_Occupational therapist \_\_\_\_Physical therapist \_\_\_\_Psychiatrist \_\_\_\_Psychologist \_\_\_\_Spiritual counselor \_\_\_\_TCM \_\_\_\_Medical doctor (type)\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Bodywork (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Please check any of the below symptoms or diseases you have experienced.

\_\_\_\_AD(H)D \_\_\_\_AIDS \_\_\_\_Alcoholism \_\_\_\_Allergies \_\_\_\_Anemia \_\_\_\_Anxiety \_\_\_\_Arthritis \_\_\_\_Asthma \_\_\_\_Bloating \_\_\_\_Cancer \_\_\_\_Chemical sensitivities \_\_\_\_Chronic fatigue \_\_\_\_Common cold \_\_\_\_Constipation \_\_\_\_Diabetes \_\_\_\_Diarrhea \_\_\_\_Dizziness \_\_\_\_Drug abuse \_\_\_\_Enviro. sensitivities \_\_\_\_Epilepsy \_\_\_\_Epstein-Barr virus \_\_\_\_Excess stress \_\_\_\_Vision \_\_\_\_Fatigue \_\_\_\_Gynecological problems \_\_\_\_Headaches \_\_\_\_Hearing problems \_\_\_\_Heart disease \_\_\_\_Hepatitis A \_\_\_\_Hepatitis B \_\_\_\_Hep C \_\_\_\_High blood pressure \_\_\_\_HIV \_\_\_\_Hyperglycemia \_\_\_\_Hypoglycemia \_\_\_\_Immune disorders \_\_\_\_Injuries \_\_\_\_Low blood pressure \_\_\_\_Male health problems \_\_\_\_Memory lose \_\_\_\_Menopause problems \_\_\_\_Menstrual irregularities \_\_\_\_Numbness \_\_\_\_Painful joints \_\_\_\_Rashes \_\_\_\_Respiratory problems \_\_\_\_Seizures \_\_\_\_Shingles \_\_\_\_Shortness of breath \_\_\_\_Sleep problems \_\_\_\_Sore throats \_\_\_\_Stiffness \_\_\_\_Stomach aches \_\_\_\_Swelling \_\_\_\_Tumors \_\_\_\_Urinary tract infections Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immune System**

Please mark condition (s) you have or are experiencing

\_\_\_\_Adenitis \_\_\_\_Allergies \_\_\_\_Autoimmune disorders \_\_\_\_Catch everything \_\_\_\_Chronic fatigue \_\_\_\_Enlarged spleen \_\_\_\_Grave’s disease \_\_\_\_Hashimoto’s thyroiditis \_\_\_\_Heal slowly \_\_\_\_Immunodeficiency \_\_\_\_Infections \_\_\_\_Low grade fever \_\_\_\_Lowered resistance \_\_\_\_Lupus (SLE) \_\_\_\_Mononucleosis \_\_\_\_Myasthenia gravis \_\_\_\_Pernicious anemia \_\_\_\_Rheumatoid arthritis \_\_\_\_\_Sick often \_\_\_\_\_Sore throats \_\_\_\_Swollen lymph glands \_\_\_\_\_White blood cell count Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about your immune system?

**Childhood diseases and syndromes**:

\_\_\_\_Allergies \_\_\_\_Asthma \_\_\_\_Atopic eczema \_\_\_\_Bronchitis \_\_\_\_Chicken pox \_\_\_\_German measles (Rubella) \_\_\_\_Measles \_\_\_\_Mononucleosis \_\_\_\_Mumps \_\_\_\_Rheumatic fever \_\_\_\_Tonsillitis \_\_\_\_Whooping cough (Pertussis) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin**

Mark any of the following conditions below that pertain to you

\_\_\_\_Acne \_\_\_\_Boils \_\_\_\_Bruise easily \_\_\_\_Dry hair \_\_\_\_Dry skin \_\_\_\_Eczema/psoriasis \_\_\_\_Hair loss \_\_\_\_Impetigo \_\_\_\_Itchy \_\_\_\_Moles \_\_\_\_Oily hair \_\_\_\_Oily skin \_\_\_\_Pimples \_\_\_\_Rashes \_\_\_\_Scars \_\_\_\_Sensitive to chemicals \_\_\_\_Skin tags \_\_\_\_Slow to heal \_\_\_\_Varicose veins Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Energy levels**

Are you satisfied with your energy levels, please describe when is the high point and low point of your daily energy levels?

Have your energy levels changed markedly at any point recently or in your past.

What preceded this change?

**Drug History**: Please list any previous medical or recreational drugs you have used in your past

**Allergies**: Do you have any allergies, what are they?

Which medicines (including herbal) have you taken for them?

When and where are your allergies least and most troublesome?

Do you have allergic reactions to any drugs or herbal medicines?

What has most helped your allergies?

**Current and/or previous Digestion**

\_\_\_\_Anorexia nervosa \_\_\_\_Belching \_\_\_\_Bulimia \_\_\_\_Changes in bowel habits \_\_\_\_Crohn’s \_\_\_\_Constipation \_\_\_\_Diarrhea \_\_\_\_Diverticulitis \_\_\_Dysentery \_\_\_\_Eating disorders \_\_\_\_Flatulence \_\_\_\_Food unappetizing \_\_\_\_Gallstones \_\_\_\_Giardia \_\_\_\_Heartburn \_\_\_\_Hemorrhoids \_\_\_\_Indigestion \_\_\_\_Irritable bowel syndrome \_\_\_\_Large appetite \_\_\_\_Liver problems \_\_\_\_Low appetite \_\_\_\_Nausea \_\_\_\_Pain after eating \_\_\_\_Parasites \_\_\_\_Shigella \_\_\_\_Stomach aches \_\_\_\_Sudden weight change \_\_\_\_Ulcer \_\_\_\_Ulcerative colitis \_\_\_\_Vomiting Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your favorite and least favorite foods?

Using a scale of 1 (least favorite) to 5 (favorite) rank the following tastes and spices

\_\_\_\_Bitter \_\_\_\_Cold (temperature) \_\_\_\_Dry texture \_\_\_\_Fatty \_\_\_\_Hot (temperature) \_\_\_\_Moist texture \_\_\_\_Pungent \_\_\_\_Salty \_\_\_\_Sour \_\_\_\_Spicy \_\_\_\_Sweet Other\_\_\_\_\_\_\_\_\_

**Body Temperature**: Please write ‘**H**’ for Hot and ‘**C**’ for Cold, if applicable to these body areas \_\_\_\_General body \_\_\_\_Arms \_\_\_\_Hands \_\_\_\_Palms \_\_\_\_Fingers \_\_\_\_Legs \_\_\_\_Feet \_\_\_\_Genital region \_\_\_\_Head \_\_\_\_Chest \_\_\_\_Stomach Other\_\_\_\_\_\_\_\_\_\_

Using a scale of 1 (least favorite/strong aversion) to 5 (favorite) rate these weather conditions

\_\_\_\_Hot \_\_\_\_Very hot \_\_\_\_Cold \_\_\_\_Very cold \_\_\_\_Damp \_\_\_\_Dry \_\_\_\_Humid

What is your favorite temperature range?

What part of the day are you warmest and coldest?

**Emotional** Mark the emotions below that are pertinent to you

\_\_\_\_Angry \_\_\_\_Anxious \_\_\_\_Attentive \_\_\_\_Bi-polar \_\_\_\_Depressed \_\_\_\_Dreamy \_\_\_\_Enthusiastic \_\_\_\_Fearful \_\_\_\_Forgetful \_\_\_\_Grumpy \_\_\_\_Happy \_\_\_\_Inspired \_\_\_\_Lethargic \_\_\_\_Manic \_\_\_\_Nervous \_\_\_\_Sad \_\_\_\_Think a lot \_\_\_\_Worry Other\_\_\_\_\_\_\_\_\_\_\_\_

**Memory**: How is your long-term and short-term memory?

Has your memory changed noticeably in the past few years?

**Eyesight**: Are you near or far-sighted, do you wear corrective lenses?

Does the prescription for these change often?

**Ears**

\_\_\_\_Ear infections \_\_\_\_Earaches\_\_\_\_Hearing loss \_\_\_\_Overly sensitive \_\_\_\_Tinnitus/Ringing \_\_\_\_Wax build-up Other\_\_\_\_\_\_\_\_\_\_\_\_

**Mouth & Throat**

\_\_\_\_Cavities \_\_\_\_Constant dryness \_\_\_\_Difficultly swallowing \_\_\_\_Excess saliva \_\_\_\_Lip sores \_\_\_\_Loose teeth \_\_\_\_Mouth sores \_\_\_\_Oral herpes \_\_\_\_Painful/tight jaw \_\_\_\_Sore gums \_\_\_\_Sore throats \_\_\_\_Swollen glands \_\_\_\_Swollen tongue Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Headaches**: Do you ever have headaches, how often? How long have you had them?

Location/type of headaches \_\_\_\_After eating \_\_\_\_Afternoon \_\_\_\_Around eyes \_\_\_\_Around temples \_\_\_\_Aversion to stimuli \_\_\_\_Back of head \_\_\_\_Band around head \_\_\_\_Before eating \_\_\_\_Chronic \_\_\_\_Cluster \_\_\_\_Constant \_\_\_\_Dull \_\_\_\_Evening \_\_\_\_Front of head \_\_\_\_Left side \_\_\_\_Migraine \_\_\_\_Morning \_\_\_\_Night \_\_\_\_Pounding \_\_\_\_Pre-menses \_\_\_\_Right side Other\_\_\_\_\_\_\_\_\_

What triggers them? Are they seasonal? If so, which season?

Other symptoms associated with the headache (i.e., stomach pain)

Are they more or less often than in the past? Does the severity or intensity vary from episode to episode? What medicines and treatments have you tried, which were most successful?

**Urinary Tract**

\_\_\_\_Bloating \_\_\_\_Blood in urine \_\_\_\_Burning urination \_\_\_\_Frequent urge to urinate \_\_\_\_Kidney/bladder stones \_\_\_\_Kidney pain \_\_\_\_Lower back pain \_\_\_\_Strong smelling urine \_\_\_\_Urinary tract infections \_\_\_\_Water retention Other\_\_\_\_\_\_\_\_\_\_\_\_ ?

**Reproductive** – Male and Female Have you had any of the following.

\_\_\_\_AIDS \_\_\_\_Candida \_\_\_\_Chlamydia \_\_\_\_Crabs/lice \_\_\_\_Gardnerella \_\_\_\_Genital warts \_\_\_\_Gonorrhea \_\_\_\_HIV \_\_\_\_Human Papilloma Virus (HPV) \_\_\_\_Syphilis \_\_\_\_STDs \_\_\_\_Trichomonas \_\_\_\_Urethritis Other\_\_\_\_\_\_\_\_\_\_

Please list any herbs or drugs you have used as treatment for the above Reproductive

**Male:** Have you had any of the following symptoms or conditions

\_\_\_\_Benign Prostatic Hyperplasia (BPH) \_\_\_\_Blood in semen \_\_\_\_Blood in urine \_\_\_\_Difficulty getting urine flowing \_\_\_\_Dribbling \_\_\_\_Erectile dysfunction \_\_\_\_Excessive sexual thoughts \_\_\_\_Frequent urination \_\_\_\_Impotence \_\_\_\_Interrupted flow of urine \_\_\_\_Libido low \_\_\_\_Orchitis \_\_\_\_Painful ejaculation \_\_\_\_Painful to urinate \_\_\_\_Penis pain \_\_\_\_Prostate pain \_\_\_\_Testicle pain \_\_\_\_Vitality low Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get up at night to urinate, how often? Does your prostate region ever hurt?

If yes, is pain dull, constant, throbbing or sharp? Is it ever painful to urinate?

Describe the pain

Does the urge to urinate interfere with your daily activities?

Do you have any problems getting and/or maintaining an erection?

Do you have any health concerns about your sexuality or vitality?

**Female**

\_\_\_\_Breast pain \_\_\_\_Cervical dysplasia \_\_\_\_Cysts \_\_\_\_Endometriosis \_\_\_\_Fibroids \_\_\_\_Infertility \_\_\_\_Miscarriage \_\_\_\_Painful intercourse \_\_\_\_Pelvic inflammatory disease (PID) \_\_\_\_STDs \_\_\_\_Tumors \_\_\_\_Unusual PAP \_\_\_\_Vaginal discharge \_\_\_\_Vaginal dryness \_\_\_\_Vaginal infection \_\_\_\_Vaginitis Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**Menstrual Cycle:** \_\_\_\_Acne \_\_\_\_Bleeding between cycles \_\_\_\_Mood swings \_\_\_\_Bloating (hands, stomach) \_\_\_\_Bloating (feet, hands, ankles) \_\_\_\_Irregular cycle \_\_\_\_Painful menses Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average number of days bleeding Approximately how many days between menses

Regular or irregular? Menstrual Blood \_\_\_\_Bright red \_\_\_\_Clots \_\_\_\_Dark colored \_\_\_\_Heavy flow \_\_\_\_Profuse flow \_\_\_\_Red \_\_\_\_Red brown \_\_\_\_Scanty flow \_\_\_\_Slow flowing Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Menopause**: Are you currently in pre, peri or post menopause

\_\_\_\_ Dry vaginal mucosa \_\_\_\_Hormone replacement therapy \_\_\_\_Hot flashes \_\_\_\_Mood swings \_\_\_\_Night sweats \_\_\_\_Osteoporosis \_\_\_\_Sore muscles Other\_\_\_\_\_\_\_\_\_\_\_\_

**Contraception Method** \_\_\_\_Birth control pills \_\_\_\_IUD \_\_\_\_Diaphragm Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular Health**: Please check the below questions pertinent to your health

\_\_\_\_Angina \_\_\_\_Arrythmias (irregular heartbeat) \_\_\_\_Arteriosclerosis \_\_\_\_Black and blue easily \_\_\_\_Bleed easily \_\_\_\_Capillary fragility \_\_\_\_Cardiac arrest \_\_\_\_Chest pains \_\_\_\_Congenital deformities \_\_\_\_Congestive heart failure \_\_\_\_Edema \_\_\_\_Fast heart beat (tachycardia) \_\_\_\_Heart attack (myocardial infarction) \_\_\_\_Heart flutter \_\_\_\_Heart irregularities \_\_\_\_Heart murmur \_\_\_\_High blood pressure \_\_\_\_Ischemia \_\_\_\_Low blood pressur \_\_\_\_Mitral valve prolapse \_\_\_\_Palpitation \_\_\_\_Pericarditis\_\_\_\_Poor circulation \_\_\_\_Rheumatic fever \_\_\_\_Slow heart beat (bradycardia) \_\_\_\_Stroke \_\_\_\_Varicose veins Other\_\_\_\_\_\_\_\_\_\_\_\_

Resting pulse rate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood pressure (avg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cholesterol (if know, LDL, HDL and total cholesterol)

Does your family have a history of heart conditions, what are they?

What are some of your other blood pressure readings over the past 3 years?

What drugs, herbal medicines or other treatments have you used?

**Nervous System:**

\_\_\_\_Anxiousness \_\_\_\_Bipolar \_\_\_\_Butterflies in stomach \_\_\_\_Cannot stay asleep \_\_\_\_Constant feeling of stress \_\_\_\_Diminished taste \_\_\_\_Depression \_\_\_\_Fear of facing a new day \_\_\_\_Fluctuating vision \_\_\_\_Hard to concentrate \_\_\_\_Involuntary spasms\_\_\_\_Mania \_\_\_\_Memory loss \_\_\_\_Nervousness \_\_\_\_Numbness \_\_\_\_Pain – constant \_\_\_\_Panic attacks \_\_\_\_Seasonal affective disorder \_\_\_\_Sudden mood swings \_\_\_\_Trouble falling asleep \_\_\_\_Twitching \_\_\_\_Worsening coordination Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your stress levels

What goes wrong with your body when stress levels are elevated?

**Respiratory**:

\_\_\_\_Asthma \_\_\_\_Bronchitis \_\_\_\_Chest pain \_\_\_\_Common cold \_\_\_\_Coughing \_\_\_\_Difficulty smelling \_\_\_\_Flu (influenza) \_\_\_\_Fluid in lungs \_\_\_\_Hay fever \_\_\_\_Laryngitis \_\_\_\_Pleuritis \_\_\_\_Respiratory inflammation \_\_\_\_Runny nose \_\_\_\_Shortness of breath \_\_\_\_Sneezing \_\_\_\_Stuffy nose \_\_\_\_Tight around lungs \_\_\_\_Trouble breathing in \_\_\_\_Trouble breathing out \_\_\_\_ Wheezing \_\_\_\_Tuberculosis Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have much congestion, which season is it worse and best?

What helps it?

Mucous- quality and/or color \_\_\_\_Clear \_\_\_\_Green \_\_\_\_Yellow \_\_\_\_Thick/sticky \_\_\_\_Thin/runny \_\_\_\_Worse in the morning, afternoon, evening, night (circle)

Have you identified foods, environmental factors or situations that worsen your breathing?

What are they?

Cough – check the symptoms which pertain to you \_\_\_\_Bloody \_\_\_\_Dry cough \_\_\_\_Hacking \_\_\_\_Itchy throat \_\_\_\_Painful \_\_\_\_Persistent \_\_\_\_Regularly \_\_\_\_Wet cough \_\_\_\_Worse at morning, afternoon, evening, night (circle) \_\_\_\_

Triggers?

Are there any other concerns you wish to share?