

Herb Haven &
Suki's Blends
7922 McBane Mill Rd
Graham, NC 27253



Suki Roth
Community Herbalist
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Please send this form to me as soon as possible before your consultation. Call if questions.

Height _____	Weight _____	Blood Type _____	Date _____
Name _____		Date of Birth _____	
Address _____		Phone _____	
Occupation _____			
Interests _____			

Present Health Status: Check each column where symptoms apply and elaborate in the space provided below. Use extra sheets of paper, if necessary.

One Check for occasional symptoms

Two Checks for frequent symptoms

Three Checks for major concern

GENERAL	CARDIOVASCULAR	SKIN
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruises
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain in Heart Area	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of Ankles/Joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eruptions
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Previous Heart Stroke/Murmur	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Psoriasis, Eczema, Dermatitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose Veins	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Warm Bodied	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Insomnia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold Bodied	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Palpitations	

MUSCLES AND JOINTS	EARS, EYES, NOSE AND THROAT	RESPIRATORY
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Backache/Upper	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Backache/Lower	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Aches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Broken Bones	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye Pains, Dry/Wet	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mobility Limitations	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Blood
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stiff Neck	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congestion
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen Joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Colds
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sprained Tendons/Muscles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsils	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Bronchitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trouble Hearing	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Teeth/Gum Problems	



GASTRO-INTESTINAL

- ☐ ☐ ☐ Belching
☐ ☐ ☐ Colitis
☐ ☐ ☐ Constipation
☐ ☐ ☐ Abdominal Pain
☐ ☐ ☐ Liver Problems
☐ ☐ ☐ Gall Stones
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Had Hepatitis
☐ ☐ ☐ Poor Appetite/Indigestion
☐ ☐ ☐ Stomach Ulcer/Duodenal Ulcer
☐ ☐ ☐ Nausea

MEN

- ☐ ☐ ☐ Urinary Discharge
☐ ☐ ☐ Prostate Trouble
☐ ☐ ☐ Blood in Urine
☐ ☐ ☐ Impotence
☐ ☐ ☐ History of STDs
☐ ☐ ☐ Infertility
☐ ☐ ☐ Low Libido

WOMEN

- ☐ ☐ ☐ Congested Breast
☐ ☐ ☐ Hot Flashes
☐ ☐ ☐ Irregular Cycle
☐ ☐ ☐ Breast Lumps
☐ ☐ ☐ Pregnancy
☐ ☐ ☐ Infertility
☐ ☐ ☐ History of STDs
☐ ☐ ☐ Abnormal Pap Smears
☐ ☐ ☐ Menstrual Cramps
☐ ☐ ☐ Low Libido
☐ ☐ ☐ Frequent Vaginal Infections

URINARY

- ☐ ☐ ☐ Excessive Urination
☐ ☐ ☐ Water Retention
☐ ☐ ☐ Burning Urine
☐ ☐ ☐ Kidney Stones
☐ ☐ ☐ Lower Back Pain
☐ ☐ ☐ Frequent Bladder Infection

Please comment below on any of the symptoms checked above that you feel will give a complete overview of your present state of health.

If you were to choose one or two EMOTIONS that seem predominant in your life, they would be: _____ and _____

Are you taking any medication? e.g., herbs, pharmaceuticals (prescription, non-prescription), Bach flowers, homeopathic remedies. ☐ Yes ☐ No What? _____

Very important: please be sure to bring all you medications with you to confirm doses.

Are you under care of a practitioner, traditional or orthodox? ☐ Yes ☐ No Explain: _____



Common Physical Activities: Please check those activities which you feel you are involved in on a regular or daily basis. Comment below.

- | | | |
|---|---|---|
| <input type="checkbox"/> Desk Sitting (How Long? _____) | <input type="checkbox"/> Jogging/Running | <input type="checkbox"/> Weight Lifting |
| <input type="checkbox"/> Sitting in a car (How Long? _____) | <input type="checkbox"/> Hiking | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Standing (How Long? _____) | <input type="checkbox"/> Bike Riding | <input type="checkbox"/> Tai Chi |
| <input type="checkbox"/> Calisthenics | <input type="checkbox"/> Horseback Riding | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Tennis | <input type="checkbox"/> Dancing |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Bending/Lifting | |

Please comment on any activities checked above and note if any condition previously mentioned on this form is aggravated by any of the above activities.

Please explain dietary preference (i.e. vegetarian, lacto-vegetarian, meat, fish, dairy, macro-biotic, etc)

Dietary Habits: Please check each item below if included in your usual diet. Two checks if you consume it on a daily basis; three checks if you have it more than once a day.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Red Meat | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Grains | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sugar | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fish | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Butter | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Honey | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poultry | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Milk | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Baked Goods | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Smoke Cigarettes? |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fruits | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cheese | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Desserts | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vegetables | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yogurt | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Seeds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Smoke Marijuana? |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Leafy greens | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fermented foods | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coffee | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Raw foods | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food supplements | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Black tea | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Indulge in any |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Seaweed | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Protein supplements | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Herbal tea | other recreational drugs? |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nuts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vitamins | | |

Please comment: _____

Please use this space to fill in any gaps this form has created in your expression of your present state of health.

Include what you have done in the past to remedy imbalances and what your expectations are for resolving present problems. What type of participation do you expect to contribute?

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Briefly note any family history of heart attack, cancer, mental illness, stroke, diabetes, breathing problems, alcoholism, etc. in parents, grandparents and siblings:



Please use this space to list your priorities for health and how best I can help you.



Please include a five-day food diary with this form.

Include all your liquids also. Feel free to use another page, or the back of this page.