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

Suki Roth
Community Herbalist
Phone: 336-376-0727
email : _sukiroth48@gmail.com

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
- ☐☐☐ Allergies
- ☐☐☐ Convulsions
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Headaches
- ☐☐☐ Nervousness
- ☐☐☐ Numbness
- ☐☐☐ Tremors
- ☐☐☐ Insomnia

CARDIOVASCULAR
- ☐☐☐ High Blood Pressure
- ☐☐☐ Low Blood Pressure
- ☐☐☐ Pain in Heart Area
- ☐☐☐ Poor Circulation
- ☐☐☐ Swelling of Ankles/Joints
- ☐☐☐ Previous Heart Stroke/Murmur
- ☐☐☐ Anemia
- ☐☐☐ Vericose Veins
- ☐☐☐ Warm Bodied
- ☐☐☐ Cold Bodied
- ☐☐☐ Palpitations

SKIN
- ☐☐☐ Boils
- ☐☐☐ Bruises
- ☐☐☐ Dryness
- ☐☐☐ Itching
- ☐☐☐ Eruptions
- ☐☐☐ Psoriasis, Eczema, Dermatitis

MUSCLES AND JOINTS
- ☐☐☐ Backache/Upper
- ☐☐☐ Backache/Lower
- ☐☐☐ Broken Bones
- ☐☐☐ Mobility Limitations
- ☐☐☐ Spinal Curvature
- ☐☐☐ Stiff Neck
- ☐☐☐ Swollen Joints
- ☐☐☐ Sprained Tendons/Muscles
- ☐☐☐ Muscle Cramps

EARS, EYES, NOSE AND THROAT
- ☐☐☐ Asthma
- ☐☐☐ Ear Aches
- ☐☐☐ Eye Pains, Dry/Wet
- ☐☐☐ Failing Vision
- ☐☐☐ Hay Fever
- ☐☐☐ Sinus Congestion
- ☐☐☐ Sore Throat
- ☐☐☐ Tonsils
- ☐☐☐ Trouble Hearing
- ☐☐☐ Teeth/Gum Problems

RESPIRATORY
- ☐☐☐ Chest Pain
- ☐☐☐ Difficulty Breathing
- ☐☐☐ Dry Cough
- ☐☐☐ Spitting Blood
- ☐☐☐ Tuberculosis
- ☐☐☐ Congestion
- ☐☐☐ Frequent Colds
- ☐☐☐ Frequent Bronchitis

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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:

_____

_____

_____

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

- ☐ Desk Sitting (How Long? _____)
- ☐ Sitting in a car (How Long? _____)
- ☐ Standing (How Long? _____)
- ☐ Calisthenics
- ☐ Aerobics
- ☐ Swimming
- ☐ Jogging/Running
- ☐ Hiking
- ☐ Bike Riding
- ☐ Horseback Riding
- ☐ Tennis
- ☐ Bending/Lifting
- ☐ Weight Lifting
- ☐ Walking
- ☐ Tai Chi
- ☐ Yoga
- ☐ Dancing

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.

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

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.