Authentic Eastern Health L.L.C
Herbal Consultation Client Form

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PERSONAL HEALTH PROFILE

Date: ________________ Name: ____

Home Phone: __________________ Work: _________________ Cell: _____________________

When is the best time to call? ____________________ Call which phone? __________________

May we leave a message? __________ Email: ____

Address: ____

Date of Birth: _____________Age:______ Weight: _____ Height: ______ Blood type: ________

Emergency Contact/Relationship: _______________________ Contact Phone: ______________

Occupation: ________________________________ Referred by: _________________________

Marital Status: ___________________

Spouse's Name: _________________ ___ Spouse's Occupation: _________________________

Living situation: people's names and relationship to you:

____

____

Do you have pets? ________________what are they? ___________________________________

Name of Primary Care Doctor: ____

Other Health Care Practitioners: ____

PRESENT HEALTH CONCERNS:

1.____

2.____

3.____

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What do you hope to achieve with this visit? ___________________________________

Date of last physical? ___________Physician's Diagnosis: _______________________

Physician's Treatment: ____

Other Health Practitioner's response:_______________ ___________________________

Do you have any allergies or chemical sensitivities? _____________________________

Please list any food allergies____

Please list any allergies to medications: ____

Please list any medications taken regularly and explain for what reason you take them:

____

____

____

____

Please list any supplements or herbs taken regularly:

____

____

____

____

Please list any childhood illnesses & medications/vaccinations taken_______________

____

What is your favorite pastime? ____

Name two dominant emotions in your life now ___________________ & ____________

Do you usually feel hot or cold? ____________________

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BODY SYSTEM HEALTH PROFILE

Please check any item listed below, rating it as follows:
1 = sometimes 2 = often 3 = major concern. Leave blank if not applicable.

Circulatory

__High Blood Pressure
__Low Blood Pressure
__Palpitations
__High Cholesterol
__High Triglycerides
__Varicose veins
__Spider veins
__Cold hands & feet
__Poor circulation
__Pain in Chest
__Previous heart attack or stroke
__Swelling in ankles/joints
__Anemia
__Dizziness
__Bruise easily
__Other:______________________

Respiratory

__Allergies
__Asthma
__Sinus congestion
__Post Nasal Drip
__Sore throat
__Lung congestion
__Difficulty breathing
__Cough
__History of Tuberculosis
__Recurrent influenza
__Cold
__Sinus infection
__Other: ____________________

Eyes, Ears, Nose & Throat

__Eye pain, wet/dry
__Failing vision
__Ear aches
__Hearing loss
__Ringing in the ears/tinnitus
__Hay fever
__Tonsillitis
__ Other:____________________

Skin

__Boils
__Acne
__Eczema
__Psoriasis
__Herpes Simplex
__Slow wound healing
__Warts
__Moles
__Skin tags

Digestive

__Mouth ulcers
__Halitosis – bad breath
__Hiatal hernia
__ Bloating
__History of Hepatitis
__Gall stones
__Hypoglycemia (low blood sugar)
__burping

__Ulcers
__Constipation
__Diarrhea

__Irritable bowel
__Polyps
__Hemorrhoids
__Bleeding from anus
__Flatulence/gas

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__Skin cancer
__Fungal, bacterial infections
__Other__________________

__Reflux/regurgitation/GERD
__Nausea
__Other _____________________

Urinary

__Bladder infections
__Kidney stones
__Water retention/swelling of ankles/legs
__Incontinence
__Painful urination
__Excessive urination
__Do you get up at night to urinate? How often?
__Low back pain
__Blood in urine
__Other______________________

Muscular/skeletal

__stiffness
__Bursitis
__Torn ligaments
__Backache – where?___________
__Broken bones – where?________
__Arthritis – where? ____________
__Restricted mobility
__Gout
__Sprains – where? _____________
__Other_______________________

Reproductive (Women)

Any testing? ____
Are you pregnant now?____
No. of Pregnancies carried to term __________ Date(s):______________
No. of Pregnancies not completed (miscarriage/abortion): ____date(s):______________
Contraceptive use: in past – types and how long__________________________________
Currently: ____
Sexually transmitted diseases, list type if known:_________________________________
Hysterectomy – Date: _______________Reason: _______________________________
Uterine fibroids____
Ovarian cysts____
Endometriosis____

___Vaginal infection
___Breast pain
___Breast lumps
___Pelvic inflammatory disease
__Vaginal itching/discharge
__Infertility

__Genital herpes
__Cervical dysplasia
__Painful intercourse
__Vaginal dryness
__Uterine prolapsed
__Other

Menstruating Women

__Irregular cycle
__Heavy menstrual bleeding
__Painful menstrual cramps
__Bleeding between cycles
__Absence of menstrual cycle
__Dramatic mood swings before cycle
__Lack of sex drive
How long between periods? ______
Describe flow:____

Menopausal Women

__Hot flashes
__Dramatic mood swings
__Vaginal dryness
__Osteoporosis
__Vaginal bleeding
__ HRT
__Lack of sex drive

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Reproductive (Men)

__Impotence
__Sexually transmitted disease – list type if known____________________
__Prostatitis
__Premature ejaculation
__Lack of sex drive
__Low sperm count
__low sperm mobility
__Benign prostatic enlargement
__Other____________

Endocrine

__Pituitary
__Pineal
__Thyroid
__Pancreas
__Diabetes
__Hypoglycemia
__Other_________

Lymphatic

__Congestion
__Swollen glands
__Infection
__Other_______

Nervous System

__Anxiety
__Irritability
__Stress
__Headaches
__Migraines
__Insomnia
__Depression
__Attention Deficient
__Hyperactivity
__Mental sluggishness
__Poor memory
__Shingles
__Other _________________

Immune System

__Auto-immune disease
__Chronic Fatigue Syndrome
__Frequent colds
__Chronic infection, i.e. HPV, HIV, Herpes, tooth infections

Past Medical History

Please list any operations that you have had w/approx. date (tonsillectomy, appendectomy, implants, etc)____

Please list any major injuries/accidents, including date:
____

Please list any traumatic experiences not medically treated (divorce, loss of job, death of loved one, etc) :
____

Family Medical History: ____

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Maternal Medical History

____

Paternal Medical History

____

Sibling Medical History

____
____

Common Physical Activities

____

Diet

Typical day

Breakfast:____
____

Lunch:____

Dinner:____

Snacks:____

Do you crave anything? (Sweet, salty, pizza, alcohol, etc)____

Food Category	**Food Use Frequency**	**Comments**

0 = never eat 1 = sometimes 2 = often 3 = often   Leave blank if not applicable.

____ Red Meat ____ Poultry ____ Fish ____ Dairy (milk, cheese, yogurt)
____ Eggs ____ Fried Foods ____ Sugar ____ Alcohol
____ Coffee/caffeine ____ Soda/diet soda ____ Water ____ Tobacco
____ Whole grains ____ White flour products ____ Vegetables ____ Fruits ____ Beans

Printed Name: ____

Signature: ____

Date: ___________________________________

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CONSENT FOR SERVICES

I, ____hereby attest and agree to the following:

1) I fully understand that Ping Jian Zhao is a lay natural health advisor who deals strictly in helping people to improve their general health and fitness through better nutrition, improved lifestyle, health habits, and positive mental attitudes.

2) I fully understand that Ping Jian Zhao is not a licensed physician and cannot diagnose diseases, prescribe drugs or recommend treatment for specific disease conditions.

3) I understand that all evaluations analysis performed by Ping Jian Zhao or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by licensed physicians.

4) I understand that Ping Jian Zhao neither claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.

5) I certify that Ping Jian Zhao or her representatives have not suggested that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Ping Jian Zhao or her representatives responsible for the consequences of my decisions.

6) I certify that I am here on this visit and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county or local government or private agency on a mission of investigation.

I have read and understand the foregoing and agree to the terms and conditions set therein. I also acknowledge that I am making a personal choice to receive educational sessions with Ping Jian Zhao, a Naturopathy Consultant. I understand that it is also my personal choice to act, or not, on any of the recommendations provided.

Date __________________________ Referred by: ____

Client Signature: ____

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CANCELLATION and RETURN POLICY

Authentic Eastern Health, LLC requires 24-hour notice of cancellation prior to scheduled appointments. I hereby agree to pay $25 to Authentic Eastern Health L.L.C in the event I do not comply with this 24-hour cancellation policy.

If I am late for my appointment, my time may be cut short in order to keep other people on schedule.

Any return of herbal supplement products should be in the original sealed package and within 30 days.

Print Name: ____

Signature: ______________________________ Date: ____________________

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