1. Personal Information

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| --- | --- | --- |
| Name:  |  | Date:  |
| Street Address:  |  |  | Phone:  |
| City, State, Zip:  |  |  | Date of Birth: (m/d/year) |
| Age & Sex: | Height: | Weight: | Place of Birth: |  |
| a. Are you presently on any medications (prescription or over the counter) or dietary supplements? (Please list and include dosages. Attach additional sheet if necessary.) |  |

1. Diet, Nutrition and General Health Practices

|  |  |
| --- | --- |
| b. How much water do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cups  | c. How many hrs of sleep on average do you get each night? \_\_\_\_\_\_\_\_\_\_\_ Hrs  |
| d. How often do you exercise? \_\_\_\_\_\_\_ Hrs per \_\_\_\_\_\_\_\_  | e. What is your energy level like?  No energy (0 1 2 3 4 5 6 7 8 9 10) High energy  |
| f. How often do you eliminate your bowels? \_\_\_\_/day \_\_\_\_/wk  | g. What is your stress level?  No stress (0 1 2 3 4 5 6 7 8 9 10) High stress  |
| h. How would you rate your overall health?  Poor (0 1 2 3 4 5 6 7 8 9 10) Great  | i. Which foods do you crave? Which foods do you dislike? |

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| --- |
| j. List any serious illnesses or surgeries you have had in the past.   |
| k. Are you presently under a doctor’s care for any condition? (If yes, please describe and give dates of onset)   |
| l. What is/are your primary health concern(s) and what do you hope to achieve through this  consultation? Please indicate when the main condition began.   |
| m. Name the two emotions you experience most often? (i.e.: Anger, irritability, sadness, worry, hopelessness, grief, fear, joy, happiness, other)  |
| n. Any additional comments which may or may not pertain to your present health. (Any odd  symptoms, emotions, etc.)   |
| o. How many people live in your household? \_\_\_\_ Are you happy with your living arrangements? \_\_\_\_ Yes \_\_\_\_ No (If “No” please explain … optional)    |
| p. What are some of your interests?    |
| q. What is your occupation? Do you like your job? Do you work with a lot of chemicals or pollutants?  |
| r. Have you ever been in an accident? (If yes, please explain)      |
| s. Were there any major events which may have occurred in your life **just prior to** the onset of your primary condition? (i.e.: Birth, Death, Divorce, etc.)        |
| t. Family Medical History:  Mother Father Siblings Grandparents  |
| u. Do you have any known allergies or sensitivities?  |

**Please indicate whether you consume the following 0-Never 1-Daily 2-Weekly 3-Monthly**

Fresh Fruits 0 1 2 3

Fresh Vegetables 0 1 2 3

Green Leafy Vegetables 0 1 2 3

Poultry 0 1 2 3

Fresh or Frozen Fish 0 1 2 3

Red Meat 0 1 2 3

Seafood 0 1 2 3

Milk 0 1 2 3

Butter 0 1 2 3

Margarine 0 1 2 3

White Bread 0 1 2 3

Soda Pop 0 1 2 3

Coffee 0 1 2 3

Refined Sugar 0 1 2 3

Cookies, cakes, pastries 0 1 2 3

Soymilk/milk substitute 0 1 2 3

Alcohol 0 1 2 3

Artificial Sweetener 0 1 2 3

**Have you been diagnosed by a licensed physician with any of the following?**

**Check all that apply.**

❑ AIDS

❑ Angina

❑ 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

❑ Graves Disease (Hyperthyroid)

❑ Hashimoto’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:

**Symptom Frequency/Severity Checklist** (on a scale of 0-5)

**0.** Never have the symptom  **1.** Rarely have the symptom **2.** Occasionally have the symptom,

effect not severe **3.** Occasionally have the symptom, effect is severe **4**. Frequently have it,

effect is not severe **5.** Frequently have symptom, effect is severe

|  |  |  |
| --- | --- | --- |
| **Head** \_\_\_ headaches \_\_\_ faintness \_\_\_ dizziness \_\_\_ insomnia \_\_\_ drowsiness \_\_\_ other **Eyes** \_\_\_ watery or itchy \_\_\_ swollen, or sticky eyelids \_\_\_ dark circles under eyes \_\_\_ blurred vision \_\_\_ spots before eyes \_\_\_ poor vision \_\_\_ cataracts \_\_\_ glaucoma \_\_\_ other **Mouth and Throat** \_\_\_ chronic coughing \_\_\_ frequently clearing throat \_\_\_ frequent sore throat \_\_\_ hoarseness \_\_\_ metallic taste \_\_\_ canker/cold sores \_\_\_ dry or itching mouth \_\_\_ grinding teeth \_\_\_ clicking jaw \_\_\_ other **Ears** \_\_\_ itchy ears \_\_\_ ear aches, ear infections \_\_\_ drainage from ear \_\_\_ ringing in ears, hearing loss \_\_\_ fullness of ears \_\_\_ poor hearing \_\_\_ other **Nose** \_\_\_ stuffy nose, smell altered  | \_\_\_ sinus problems \_\_\_ excessive mucus \_\_\_ hay fever \_\_\_ sneezing attacks \_\_\_ other **Gastrointestinal** \_\_\_ nausea or vomiting \_\_\_ diarrhea \_\_\_ constipation \_\_\_ bloated feeling \_\_\_ belching or passing gas \_\_\_ stomach pains or cramps \_\_\_ difficulty swallowing \_\_\_ gingivitis or gum disease\_\_\_ black stools \_\_\_ blood in stool \_\_\_ hemorrhoids \_\_\_ heart burn/reflux \_\_\_ rectal pain \_\_\_ loose stools \_\_\_ other **Musculoskeletal** **\_\_\_** neck pain \_\_\_ back pain \_\_\_ pains or aches in joints \_\_\_ reduced range of motion \_\_\_ arthritis \_\_\_ stiffness \_\_\_ pains or aches in muscles \_\_\_ weakness \_\_\_ numbness \_\_\_ swelling in hands and feet \_\_\_ other **Cardiovascular/Circulatory** \_\_\_ irregular heart beat \_\_\_ rapid or pounding heart \_\_\_ chest pain \_\_\_ other \_\_\_ high blood pressure  | \_\_\_ fainting \_\_\_ hyperactivity \_\_\_ low blood pressure \_\_\_ cold hands or feet**Neuropsychological** \_\_\_ poor sleep \_\_\_ depression \_\_\_ seizures \_\_\_ headaches \_\_\_ lack of coordination \_\_\_ poor memory \_\_\_ irritability \_\_\_ mood swings \_\_\_ anxiety, fears \_\_\_ nervousness \_\_\_ anger \_\_\_ aggressiveness \_\_\_ panic attacks \_\_\_ high stress levels \_\_\_ difficulty concentrating \_\_\_ loss of balance \_\_\_ numbness\_\_\_ peripheral neuropathy\_\_\_ shaky hands\_\_\_ migraine \_\_\_ "spacey"/foggy feeling \_\_\_ poor memory \_\_\_ poor comprehension \_\_\_ poor concentration \_\_\_ poor physical coordination \_\_\_ difficulty making decisions \_\_\_ stuttering \_\_\_ learning disabilities \_\_\_ other  |
| **Immune System** \_\_\_ frequent illness \_\_\_ frequent infections \_\_\_ poor wound healing\_\_\_ swollen lymph nodes **Urinary System** \_\_\_ painful urination \_\_\_ urinary urgency \_\_\_ incontinence \_\_\_ frequent urination \_\_\_ kidney stones \_\_\_ inability to hold urine \_\_\_ blood in urine \_\_\_ irregular flow \_\_\_ decreased flow \_\_\_ difficulty starting/stopping slow  **Reproductive** (women only) \_\_\_ heavy cramping \_\_\_ bloating \_\_\_ PMS \_\_\_ irritability/Moody \_\_\_ heavy bleeding \_\_\_ light bleeding \_\_\_ vaginal odor \_\_\_ vaginal discharge \_\_\_ vaginal itching \_\_\_ frequent yeast infections \_\_\_ breast tenderness  Is your cycle longer than 28 days? Yes or No  Is your cycle shorter than 28 days? Yes or No  Is your libido (desire for intercourse) low, medium or strong?  | **Energy and Activity** \_\_\_ restless \_\_\_ fatigue, sluggishness \_\_\_ apathy, lethargy **Respiratory** **\_\_\_** chronic cough (dry or phlegm? \_\_\_\_\_\_\_\_\_\_\_\_ )**\_\_\_** post nasal drip\_\_\_ chest congestion \_\_\_ asthma, bronchitis \_\_\_ pneumonia \_\_\_ coughing up blood \_\_\_ shortness of breath \_\_\_ difficulty breathing \_\_\_ difficulty breathing when laying down   **Skin** \_\_\_ acne \_\_\_ eczema\_\_\_ rosacea\_\_\_ hives, rash, or dry skin \_\_\_ hair loss or thinning \_\_\_ flushing or hot flashes \_\_\_ excessive sweating \_\_\_ change in color \_\_\_ other**Weight** \_\_\_ binge eating/drinking \_\_\_ water retention \_\_\_ crave sweet foods \_\_\_ crave salty foods \_\_\_ crave bitter foods\_\_\_ purging/laxative use  | **Please check all that apply:**❑ bad breath❑ brittle fingernails❑ itchy nose or ears❑ sensitive to smells❑ sensitive to sounds❑ sensitive to lights❑ restless dreams/nightmares❑ night terrors❑ restless leg syndromeOther:  |

Are there any other concerns that have not been addressed?

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Constitutional Questionnaire Results (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Statement**

I understand that I am here to learn about holistic wellness and better health practices and that I will be offered information about herbs, food, supplements, and lifestyle modifications as a guide to general good health and this is considered to be for educational purposes only.

I fully understand that those who counsel me are not medical doctors and I am not here for medial-diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit (in person or remote) as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed by LEANNE HOLCOMB are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

I also 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.*

 \_\_\_\_\_\_\_\_ Initial here to indicate that you have been advised of all consultation fees.

 \_\_\_\_\_\_\_\_ Initial here to indicate that you are aware that these services are not covered by insurance and that you are responsible for all fees incurred.

Date.\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Guardian for minor child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Leanne Holcomb, Herbalist**

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