

Health Consultation



TAKING CHARGE OF YOUR HEALTH

Restoration of your health is a cooperative process between you, the client, and your health care practitioner. After the consultation, your **active** participation is critical to your success.

MY RESPONSIBILITY

During your consultation, I will interpret your intake, health history and assess results from lab work. With this information and my knowledge and experience, I will recommend an herb and supplement program to strengthen your body systems. My responsibility is to give you the best program possible. Because every person's body is different, it is not always possible give the perfect program the first time. By reviewing your body's response and making any necessary changes to your program, I will be able to help you meet your health goals. This will require you doing your part.

YOUR RESPONSIBILITY

Your role is to participate in this process. Although positive thoughts have been shown to improve health, you do not have to believe that herbs can help you feel better. All you have to do is take them, and do the following three things.

1. You must stay in communication. If you have *important* questions, call me at (225) 647-6879. If you are experiencing any symptoms (nausea, diarrhea, vomiting, constipation, flu symptoms, dizziness, headache), it is important to call me. It is my goal to give you a program that supports healing without unnecessary symptoms, but, if you have symptoms, do not take over-the-counter remedies, call me. (See *section on "Healing Crisis."*) My voice mail is always available and I will call you back as quickly as I can.

2. You must follow the program that you have chosen to the best of your ability. The healing process is slow and gradual. Your *continued* participation is more important than a dramatic change that only lasts a week or two. The first hurdle is to establish a habit of taking the herbs daily. The second hurdle is to learn to plan ahead and order herbs *before* you run

out. If money is an issue, ask me about discounts.

3. You must listen to your body and learn what heals and what does not. Often we get sick because our attention is on everything in our life but our health. We have forgotten to take care of our body. If you have symptoms, your body needs attention. It does no good to come in to see me, like bring your car to the mechanic, and ask me to, "Fix it!" You're the reason you're not feeling well and you can best determine your path to health. I am a resource. I can teach you and give you information. ***The choices and the responsibility are yours.***

You must learn to listen to your body. You must respond to its needs for rest and proper nutrition. Become a cooperative partner in your life. Many of us have had times when our body felt like a piece of baggage that we had to drag around. At these times it may have felt that your body was an enemy. Nourishing your body will help you overcome these feelings.

HEALING CRISIS

This describes the process that the body goes through when the blood is pure and full of nutrition, circulation is improved and there is proper nerve force and sufficient rest. While it is my goal to avoid a crisis in healing, with exercise, a nutritious diet and sufficient rest, a healing crisis sometimes occurs.

The healing crisis is the result of an industrious effort by every organ of the body to eliminate waste and prepare for regeneration. Through this constructive process, old tissue is replaced by new. This crisis is recognized by a heavy elimination of mucus or catarrh. The experience of a healing crisis is much like that of an illness, because the symptoms are similar. But there is one important distinction, that is elimination. In the healing crisis, the body has the energy and strength to eliminate the toxic wastes that caused past problems. It is important to allow this purification and not suppress the elimination with over-the-counter remedies. A healing crisis is positive. Better health is just around the corner



Client Intake Form

Name _____

Address _____

City _____ State _____ Zip _____

Telephone: Home () _____ Work () _____

E-mail Address _____

Birth date _____ Referred By _____

Areas Needing Attention:

#1 Priority:

Does anyone else in your family have this health challenge? Yes No Who? _____

How many **years** have you had the symptoms of this complaint?

The third Golden Rule of Health States: Nothing heals in the human body in less than 3 months plus one month for every year you had the symptoms.

Therefore, it will take at least + 3 = months to heal.

On a scale of 1 to 10, 1 being worst and 10 being best, where would you rate your health? _____

What is your passion? _____

Where do you want to be in five years? _____

Please note: State law does NOT allow any person to provide nutritional advice or give advice concerning proper nutrition--which is the giving of advice as to the role of food and food ingredients, including dietary supplements. This state law does NOT confer authority to practice medicine or to undertake the diagnosis, prevention, treatment, or cure of any disease, pain, deformity, injury or mental or physical condition and specifically does not authorize any person other than one who is a licensed health professional to state that any product **might** cure any disease, disorder, or condition.

I understand that, if the area for which I am requesting attention is a medical or psychological problem, it is my responsibility to seek proper medical or psychological care. I understand that Iridology, Biological Terrain Assessment, Bio Scans and Blood Education are adjunctive techniques.

Date _____ Signature _____

Client Intake Form

Have you **ever** had or do you **now** have any of the following?

EVER	NOW	
yes	yes	(if no, leave blank)
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	<input type="checkbox"/>	Allergies or hay fever
<input type="checkbox"/>	<input type="checkbox"/>	Serious anemia or other blood diseases
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, gout, or painful joints
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Back ache or back injury
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, leukemia or tumors
<input type="checkbox"/>	<input type="checkbox"/>	Cataract <input type="checkbox"/> left eye <input type="checkbox"/> right eye
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, seizures or epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough, emphysema or other chronic lung diseases
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or sugar in urine
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or colitis (chronic), rectal bleeding or other rectal ailment
<input type="checkbox"/>	<input type="checkbox"/>	Chronic constipation, (specify # of bowel movements per day) _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction or abuse (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear problems or loss of hearing
<input type="checkbox"/>	<input type="checkbox"/>	Female organ abnormality
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder stones
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Goiter or thyroid condition
<input type="checkbox"/>	<input type="checkbox"/>	Headaches (disabling) or migraine
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack or other heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	Hernia (rupture)
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension or high blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Immunological deficiency (AIDS or ARC)
<input type="checkbox"/>	<input type="checkbox"/>	Persistent indigestion or peptic symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Kidney condition, kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Liver conditions <input type="checkbox"/> cirrhosis <input type="checkbox"/> jaundice <input type="checkbox"/> hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged or swollen lymph nodes (glands)
<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapsed
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis/strokes
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Psychological/emotional counseling
<input type="checkbox"/>	<input type="checkbox"/>	Institutionalized for Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Serious skin disease, melanoma, psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers of stomach or duodenum
<input type="checkbox"/>	<input type="checkbox"/>	Loss of urine control, bladder problems, or difficult urination
<input type="checkbox"/>	<input type="checkbox"/>	Irregular vaginal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease

Have you had or do you now have any other condition not listed above? Please describe:



Client Intake Form

Are you presently under a Doctor's care? Yes No What for? _____

Doctor's name and telephone _____

Therapist's name and telephone _____

Are you presently taking medication? Yes No

What are the Medications for? _____

Please list Medications, exact spelling please.

Do you regularly drink alcohol? Yes No Do you regularly smoke? Yes No

Do you regularly take drugs? Yes No

Does the diagnosis or treatment of a particular injury, disease, or other pathological condition concern you? Yes No If Yes, what is your concern? _____

Do you have any implanted devices, such as hips, knees, elbows, shoulders, breasts, hernia mesh, etc.? Yes No

Do you now or did you previous have? Circle all that apply - measles, mumps, chicken pox, herpes, Epstein Bar, chronic fatigue, mono, HIV, hepatitis A, B or C? Yes No

Have you ever had any head injuries? Yes No

Have you ever had any chemical exposure? Yes No

Have you **every** smoked? Yes No ____ # years

Have you been exposed to second hand smoke? Yes No ____ # years

of Meals per day ____ Hours of sleep per night ____ Hours of exercise per week ____

FAMILY MEDICAL HISTORY - List **chronic illnesses** and or cause of death and age of death.

Mother _____

Mother's Mother _____

Mother's Father _____

Father _____

Father's Mother _____

Father's Father _____



Client Intake Form

If you currently have the symptoms or health problems indicated, place a 1, 2, or 3 in the column marked „c“ for „Current“. If you have experienced the problem in the past (but do not currently have it), put a 1, 2, or 3 in the column marked „P“ for „Previous“. If the problem is (or was) mild, put the number 1 in the column. If the problem is (or was) a moderate one, put the number 2 in the column. If the problem is (or was) severe, put a 3. Total the numbers in each column in the space indicated.

Earth Stressed	C	P
Frequent bad breath		
Belching after meals		
Nausea/Vomiting		
Abdominal pain or discomfort		
Loose stool		
Cravings for sugar		
Intestinal gas/bloating		
Sour stomach		
Temporary loss of appetite		
Foul taste in mouth		
Earth Stressed Totals		

Earth Weakened	C	P
Poor protein digestion		
Low energy levels		
Sick for more than 1 year		
Shallow breathing		
Constant bloating		
Poor muscle tone or unable to gain weight		
Ulcers or stomach pain		
Prolapsed colon		
Chronically poor appetite		
Colitis or other bowel irritations		
Earth Weakened Totals		

Wood Stressed	C	P
Nausea/Vomiting		
Alternating diarrhea & constipation		
Anger/Defensiveness		
Occasional headaches or dizziness		
Stiff & Aching muscles		
Cold hands & feet		
Discomfort under right side of rib cage		
Fatigue in the mornings		
Sensation of foreign object (lump) in throat		
Bitter taste in mouth		
Gallstones or indigestion after eating fats		
Wood Stressed Totals		

Wood Weakened	C	P
Hypoglycemia or afternoon fatigue		
PMS symptoms (females) "moody" (males)		
Food Allergies		
Frequently fatigued		
Depressed/Discouraged		
Hypochondriac feelings		
Frequent skin eruptions (acne, rashes, etc.)		
Gallstones/Fat cravings		
Low resistance to disease		
Difficulty getting to sleep		
Difficulty waking up in the morning		
Wood Weakened Totals		



Client Intake Form

Metal Stressed	C	P
Difficult Breathing		
Coughing		
Sinus congestion		
Wheezing		
Asthma/Bronchitis		
Swollen lymph glands		
Defensive or dogmatic		
Shortness of breath		
Allergies/Hayfever		
Sinus headaches		
Metal Stressed Totals		

Metal Weakened	C	P
Infections in lungs		
Pneumonia		
Tuberculosis		
Chronic lung weakness		
Feeble speaking		
Tightness in chest		
Frequent colds and flu		
Withdrawn/Sad/Grieving		
Dry cough		
Excessive sweating		
Metal Weakened Totals		

Fire Stressed	C	P
Nervous or excitable		
Dizzy or "light-headed"		
Toss and Turn" in sleep		
Always "on the go"		
Too much stress		
Anxiety/Muscle tension		
Heart palpitations		
Talk too fast		
Highly "emotional"		
Difficulty relaxing		
Fire Stressed Totals		

Fire Weakened	C	P
Extreme Fatigue		
Cold hands & feet		
Frigidity or impotence		
Muddled thinking		
Waking up frequently		
Restless dreaming		
Forgetful/Absent-minded		
Feeling "overwhelmed"		
Feeling "burned-out"		
Night sweats		
Fire Weakened Totals		

Water Stressed	C	P
Water retention/edema		
Sluggish/Tired		
Occasional backache		
Burning urination		
Urinary infections		
Prostate problems (male)		
Vaginal irritation (female)		
High blood pressure		
Wake up at night to urinate		
Fearful/Indecisive/Timid		
Joint swelling or pain		
Water Stressed Totals		

Water Weakened	C	P
Impotence (male)		
Chronic back pain		
Arthritis or Gout		
Osteoporosis (weak or broken bones)		
Dark circles under eyes		
Neck pain/stiff neck		
Spinal Problems		
Leg cramps/pain		
Kidney stones		
Weak legs/knees/ankles		
Water Weakened Totals		



Client Intake Form

Heat Stressed	C	P
Fever with chills		
Headaches		
Sore throat		
Eye irritation		
Gum irritation		
Skin infections/rashes		
Earaches		
Swelling and pain		
Nosebleeds		
Burning sensations		
Heat Stressed Totals		

Heat Weakened	C	P
Frequent thirst		
Dry cough or sticky phlegm		
Dry mouth		
Night sweats		
Dry or wrinkled skin		
Dizziness		
ringing in ears		
Poor memory		
Dry stool		
Burning skin		
Heat Weakened Totals		

Energy Stressed	C	P
Depression		
Heavy feelings		
Taking tranquilizers or anti-depressants		
Sensation of foreign body in throat		
Frequent headaches or dizziness		
Insomnia or difficulty going to sleep		
Migrating pains		
Hypochondriac feelings		
Nightmares or restless dreams		
Hysteria or other mental/emotional illness		
Energy Stressed Totals		

Energy Weakened	C	P
Extreme or chronic fatigue		
Poor self-esteem		
Anorexia/Poor appetite		
Shortness of breath		
Autoimmune disease: lupus,arthritis,cancer		
Indifference, discouragement		
Prolonged stress		
General feelings of weakness		
Slow recovery from illness		
Have been ill for over one year		
Energy Weakened Totals		

Each element (earth, wood, metal, fire, and water) is related to specific body systems and organs. The **EARTH** element is related to the stomach, spleen and pancreas; the **WOOD** element to the liver and gallbladder; the **METAL** element to the colon, lungs, lymphatic and immune systems; the **FIRE** element to the glands, nervous, and circulatory systems; and the **WATER** element to the kidneys, bladder and structural systems. The **ENERGY** constitution is related to the flow of (chi) in the body, while the **HEAT** constitution is related to the states of heat and dryness in the body systems.

When an element is **STRESSED**, it suggests that the corresponding organs and systems are overactive, hyperactive, or acutely irritated. When an element is **WEAKENED**, it suggests that the corresponding organs and systems are under-active, hypoactive or chronically weakened.



Client Intake Form

For Office use – Do not fill out – Thank you.

Category	Earth		Wood		Metal		Fire	
	Stress	Weak	Stress	Weak	Stress	Weak	Stress	Weak
Totals								
Current "C" Totals								
Previous "P" Totals								
Current + Previous								
Stressed + Weakened								

Category	Water		Heat		Energy		Example	
	Stress	Weak	Stress	Weak	Stress	Weak	Stress	Weak
Totals								
Current "C" Totals							5	3
Previous "P" Totals							3	6
Current + Previous							8	9
Stressed + Weakened							17	