Cosmeos Natural Health & Beauty Herbal Consultation In-Take Form

Name__________________________

Age ___________

Address: Street

____

City ____________________ Zip Code ________________

Phone number with area code best to be reached/message

____

Email address:

____

Employment Status: Full time ___ Part Time ___ Student ___ Retired ___ Unemployed
___ Other ___

Occupation ___________________________ Marital Status _________________

Children
(#/ages) _______________________

Note: The case history notes and medical information recorded during the consultation
are kept strictly confidential and will be kept in a locked file cabinet of this office. Old
documents will be appropriately disposed of such as use of a paper shredder.
Information contained here will not be released to any person except when you have
authorized me to do so. You must sign a release form in order to do so.

Please complete this questionnaire as thoroughly as possible.

Where did you hear about Cosmeos Natural Health & Beauty?

____

What are the major health concerns that brought you here today?

____

____

____

____

____

____

____

When did this condition(s)
begin?____

Are you currently receiving care from any other health professional? (Name)

____

For what condition(s)?

____

____

____

Are you currently using Supplements and Medications?
Medication/Supplement/Herb Name: Potency/Frequency

____

____

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____

____

Do you have any infectious diseases that you know of? Yes ____ No ____ If yes please
list

____

Is there any chance that you are pregnant? Yes ____ No ____ Nursing?
Yes____No ____

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc)?

____

____

____

Can you take remedies made in alcohol?

____

____

Have you had any operations or been in hospital for some other reason? (date and reason)

____

____

____

____

____

Accidents/ Injuries (briefly describe)
More than 5 years ago

____

____

Less then 5 years ago

____

____

Family Medical History

Please complete this section only for any family members with particular health problems.

AGE (if deceased, age of death)
HEALTH PROBLEM
Father
Mother
Brothers/Sisters
Children
Other close
Blood relatives

Personal Health Habits

Height ____ Current Weight _____Weight 1 year ago ________
Are you a current smoker? _____ How many years?____ Amount per day ? ____ Have
you smoked in the past? ____
Do you use recreational drugs? ____ What? _____________ Frequency? ____
Are you involved in regular exercise? ____ Frequency? _______ Type? ______________
Duration? ______________________

Diet

Do you drink alcohol? ____ What? ____________________________
Frequency? ____
Do you drink coffee? ____ How much? ____ Tea? ____ How much? ____ Water____
How much? _____
What do you like about your dietary habits and what would you like to change?____

____

____

____

____

Do you now follow or have you ever followed a restricted diet? Please describe and indicate when:

____

____

Health Concerns
Please check off if you have experienced any of these in the last 3 months.
Skin and Hair
____ Rashes ____ Poor healing sores ____ Hives ____ Itching
____ Eczema ____ Pimples ____ Dandruff ____ Loss of hair
____ Recent moles ____ Change in skin texture ____ Varicose veins
Any other noted problems with skin, nails or hair?
____

Head, Eyes, Ears, Nose and Throat
____ Poor vision ____ Cataracts ____ Glaucoma ____ Earaches
____ Blurred vision ____ Poor hearing ____ Ringing in ears ____ Sore throat
____ Canker sores ____ Cold sores ____ Grinding teeth ____ Nosebleeds
____ Facial pain ____ Clicking jaw ____ Eye pain ____ Sinus congestion
____ Mucous in throat ____ Dizziness ____ Frequent colds ____ Spots in front of eyes
____ Swollen glands
Any other problems with the head?
____
____

Cardiovascular
____ High blood pressure ____ Low blood pressure ____ Chest pain ____ Fainting
____Irregular heart beat ____ Cold hands or feet ____ Ankle swelling ____ Palpations
____ Easy bruising ____ Varicose veins ____ Blood clots ____ Breathing difficulties
Any other problems with the heart or circulation?
____
____

What is your blood pressure reading? ______________
Gastro-Intestinal
____ Nausea ____ Vomiting ____ Diarrhea ____ Constipation
____ Black stools ____ Bad breath ____ Indigestion ____Abdominal pain
____ Heartburn ____Gas ____ Blood in stools ____ Mucous in stools
____ Rectal pain ____ Hemorrhoids ____ Bloating ____ Food cravings
____ Poor appetite ____ Gallstones ____ Ulcers ____ Difficulty swallowing
____ Colitis/ IBS ____ Liver problems
____ # of bowel movements per day
____ Loose ____ Normal ____ Hard?
Stools: ____ float ____ sink ____bad odor ____no odor ____ blood in stool
Do you rely on any of the following for bowel elimination? Yes ___ No ___ How ofter?
___
____ Enemas ____ Laxatives ____ Purgatives ____ What type/brand?
____

Any other digestive problems?
____
____
____

Respiratory
____ Cough ____ Bronchitis ____ Asthma ____ Coughing blood
____ Pneumonia ____ Pain on breathing ____ Shortness of breath without exertion
____ Difficulty breathing when lying down ____ Production of phlegm, if yes what color? ______________________
Any other problems with breathing?
____
____

Urinary
____ Pain on urination ____ Frequent urination ____ Blood in urine
____ Urgency of urination ____ Kidney stones ____ Irregular flow
____ Impotency ____ Inability to hold urine ____ Decrease in flow
____ Water retention ____ Burning urine ____ Difficulty stopping or starting
____ Prostate enlargement ____ Interstitial cystitis
Any other problems with urination?
____
____
____

Musculoskeletal
____ Neck pain ____ Muscle pain ____ Stiffness ____ Back pain
____ Muscle weakness ____ Broken bones ____ Reduced range of movement
Do you see a Chiropractor or Massage Therapist (name)?____
Any other musculoskeletal problems?
____
____

Reproductive
____ Age of first period ____ Length of cycle ____ Duration of bleeding ____ Clotting
____ Light Flow ____ Color of Blood ____ Heavy Bleeding ___ Irregular Bleeding
____ Severe menstrual cramps ____ Discharge ____ Color of Discharge ____ Herpes
____ Cervical dysplasia ____ Endometriosis ____ Uterine cysts ____ Fibroids
____ Vaginal itching ____ Anemia ____ Pelvic inflammatory disease ____ Infertility
____ Hot flashes ____ Dry vaginal lining ____ Osteoporosis ____ ERT therapy
____ Break through bleeding ____ Dramatic mood swings ____ Absence of cycle ____
Hysterectomy

____ Pain with intercourse ____ Tubal ligation ____ Mastectomy ____ Lumpectomy
____ Vaginal infection, If yes what type and for who long?
____
____
____ PMS if yes, list symptoms
____
____
____
____
Menopausal Difficulties? List experiences and/or symptoms you are currently experiencing:
____
____
____
____
Do you have breast implants? ____ Have you noted any problem with these?
____
____
Date & result of last PAP
____
____
____
____ # of pregnancies ____ # of births ____ Miscarriages ____ Premature births
____ Terminations ____ Tubular Pregnancies

Contraceptive History: List the kind(s) if contraceptives you have used, if any, and for how long:

Birth Control pills
____
____
____ IUD ____Condoms ____Diaphragm ____Rhythm ____ Chemical spermicides
Any other gynecological problems?
____
____
____

Neuropsychological

____ Poor sleep ____ Poor memory ____ Numbness ____ Depression
____ Irritability ____ Anxiety ____ Seizures ____ Migraine
____ Headaches ____ High stress levels ____Loss of balance ____ Lack of coordination
____Difficulty concentrating ____ Foggy or spacey feeling
Hours of sleep per 24 hours ______

Any other neurological problems?
____
____
____
Stress management techniques:
____
____
____
____

General

____ Fatigue ____ Fevers ____ Chills ____ Night sweats
____ Excessive thirst ____ Slow metabolism ____Sudden energy drops ____ Intolerance
to heat or cold
Any other health concerns of problems?
____
____
To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins encountered beyond daily life?
____
____
____
____

Personal

How do you feel about the following areas of your life? Please check appropriate boxes
and make any comments you would like to
EXCELLENT/GOOD/ FAIR/ POOR/ COMMENTS
Self
Work
Spouse or
Significant other
Sex
Family
Personal Goals/
Life Purpose

Current State of Emotions and Feelings

Please take a moment to answer the following questions:
Are you able to express your feelings and emotions?
____
____
Is there an excess of stress in your life?
____
____

Do you have tools or techniques to relieve stress?

____

____

____

Are you satisfied with your current
environment?____

____

____

____

If there is one thing in your life that you would like to change right now, what is it? Can
you change it?

____

____

____

____

____

Are you a .nervous type. person? What are the things, which make you most nervous?

____

____

____

____

Do you sleep well?

____

____

____

What feelings do you most often experience in your life? Joy, happiness, anger, sadness,
fear, sympathy, worry, depression or other?

____

____

Vision Statement

What is your goal or achievement that would most like to accomplish with this visit?

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Ideally what state of health can you visualize achieving for yourself?

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____
____
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____
____

Waiver of Liability

I, the undersigned, hereby confirm that I am consulting with Stacey Williams of Cosmeos Natural Health & Beauty, of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the above named Master Herbalist will offer an assessment of my general health and will make dietary and herbal recommendations. I understand the importance of frequent monitoring to revise the suggested protocol as the symptom picture changes.

Signature ____ Date _____________