Greenwood Herbals
561 Parsonsfield Rd
Limerick, Me 04048
207-793-3553

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so. Please complete the questionnaire as completely as possible. Thank you.

Personal Information:

Today's Date:		
Name:		
Address:		
Home Phone #:	**Work Phone #:**	**Best time to Call?**
Age:	**Birth Date:**	**Male or Female:**
Weight:	**Height:**	
Share your home with		
Do you have a child/children?	**If yes, ages:**	
Occupation		
Date of Last Physical Exam:	**Results:**	
What type of Health Practioners do you work with?		
List all other health care practitioners you work with		
What are your major health concerns that brought you here today?		
When did this begin?	**Has anything recently changed?**	
Are you taking any medications (prescriptions or otherwise?) If yes, please list them.		
Is there any reason why you could not take remedies made in alcohol?		

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Do you engage in any of the following activities?

Exercise? (describe)		
Relaxation program? (describe)		
Interests and Hobbies?		
Describe your current energy level?		
How would you describe your stress level?		
Cigarettes/cigars/chewing tobacco	**Drink Alcohol (what kind, how much and how often?)**	
Spiritual Practice	**How many hours do you sleep at night?**	**How would you describe your sleep?**
Do you like your work?		
Name two dominant emotions in your life at this time	**Joy Anger Fear Grief Happiness Sympathy Anxiety Sadness Peace**	

Family Health History

High or Low Blood Pressure	
Arthritis	
Depression	
Mental Illness	
Asthma	
Liver Disease	
Ulcers	
Diabetes	
Kidney/Bladder Problems	
Thyroid Imbalance	
Cancer	
Emphysema	
T.B.	
Auto-Immune Disorders	
Menstrual or Pregnancy Difficulties	

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Symptoms Checklist:

Please check any of these symptoms or diseases you have had in the past or present and dates to indicate when they occurred. If unsure put a question mark and we will discuss.

	Date		Date		Date		Date
Allergies		**Accident**		**Headaches**		**Arthritis**	
Menstrual Pain		**Incontinent**		**Painful Urination**		**Bloating**	
Memory Loss		**Eye Irritation**		**Hearing Problems**		**Asthma**	
Hyperglycemia		**Hypoglycemia**		**Chemical Sensitivities**		**Rashes**	
Sleep Problems		**Drug Abuse**		**Alcoholism**		**Fatigue**	
Diabetes		**Night Sweats**		**High Blood Pressure**		**Low Blood Pressure**	
Diarrhea		**Seizures**		**Teeth Grinding**		**Numbness**	
Constipation		**Shingles**		**Fainting**		**Anemia**	
Eczema		**Earaches**		**Swollen glands**		**Neck Pain**	
Cancer		**Tumors/Cysts**		**Congestion**		**Nausea**	
Heartburn		**Bad Dreams**		**Poor Concentration**		**Gas**	
Bruise Easily		**Indigestion**		**Loneliness**		**Phobias**	
Anger Outbursts		**Back Pain**		**Sexually Transmitted Disease**		**Mania**	
Sinus Infections		**Painful Joints**		**Swelling**			

Have you ever been vaccinated?	
Have you ever had major surgery? (Date)	**Have you ever had any severe injuries? (Date)**

Is there any other information that you think we need to know about you?

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Diet:

Describe a typical Day:

Breakfast	Lunch	Dinner	Snacks

Please estimate how many servings you eat of the following foods in one week.

Red Meat	**Green Vegetables**	**Oils**	**Coffee**
Poultry	**Yellow Vegetables**	**Wheat Products**	**Tea (caffeinated)**
Fish	**Fruit**	**Whole Grains**	**Alcohol**
Beans/Legumes	**Milk/Yogurt**	**Pastries/Sweets**	**Herbal Tea**
Soy Products	**Cheese**	**Chocolate**	**Dining Out**
Vegetable Proteins	**Butter**		
How much water do you drink in one day?			

If you could change anything about your eating habits what would it be?

Do you have food cravings?

Please list any vitamins, herbs or supplements you currently take with the dosage.

Please list any herbal therapies you take with the dosage.

Please list any pharmaceutical medications you are taking.

Please list any essential oils you are taking:

Please list any recreational drugs you are taking.

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Waiver of Liability

Clients are reminded that it is their personal right and responsibility to make educated choices in their own and their family's health care. Greenwood Herbals does not make these choices for the client but provides educational resources in the historic and traditional uses of herbs.

I thoroughly understand that only a physician (MD) OR (DO) can diagnose, treat and prescribe medicines for illness. The role of the herbalist in any healing process is not to consider a client's individual systems but to consider a client as a whole person and to consult the client concerning lifestyle, diet, and herbal recommendations.

I, the undersigned, understand the above paragraph, and release Greenwood Herbals and all associates of this business from any liability. I also confirm that I am consulting with this named individual of Greenwood Herbals on my own free will. I understand that there will be no diagnosis made, or prescription given, but that an assessment of my general health will be made with lifestyle, dietary and herbal recommendations.

Client's Signature: _____

Date: _____

Herbalist's Signature: _____

Date: _____