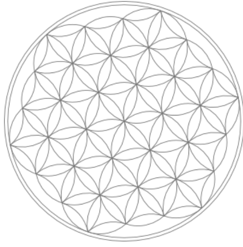


LEONURUS

Clinical Herbalism – Plant Medicine
Patient Information and Health History

Date: ___________________________ Name: ____

Gender: (M)(F) Date of Birth: (DD/MM/YR) Age: __________ Marital Status: ____________________________________

Address: ____ Postal code: ______________________

Phone (h): _______________________ (c): _______________________ E-mail: _______________________________________

Occupation: ____

Name of MD: ____ Phone: ____________________________

Name & Modality of other Health Practitioners: ____

Emergency contact: ____ Phone:____________________________

Referred by: ____

What is the main condition for which you are seeking treatment?

____

____

____

What is the history of this condition (ie. when did it start, what makes it worse/better? what have you already tried for treatment?)

____

____

____

Medical History:

List any previous **illnesses** including childhood illness or chronic viral infections, any **surgeries**, **traumas** or accidents, even if unrelated to your current condition.

____

____

____

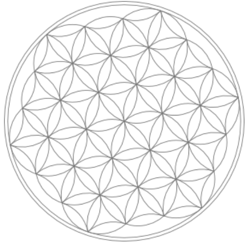
Are there any conditions that are significant in your **family's medical history**? (eg. heart disease, cancer, stroke, high blood pressure, kidney disease, diabetes, asthma, ulcers, mental/emotional disorders, etc)

____

____

____

Are you currently pregnant? (Y) (N) (Trying) Please briefly share history of the following:
Pregnancies: ____
Terminations: ____
Miscarriages: ____
Births: ____



LEONURUS

Clinical Herbalism – Plant Medicine
Patient Information and Health History

Please list any allergies (medication, food, seasonal, etc.) and the reaction you have:

____

____

____

Please list all medications you are currently taking: (include birth control, supplements, and vitamins)

____

____

____

Date of last physical exam: ________________________

Describe your health when you were a:

Child:

____

____

____

Adolescent:

____

____

____

Current:

____

____

____

Dental History:

List any previous dental surgeries:

____

____

____

Number of amalgam fillings, if any? _____________

Lifestyle:

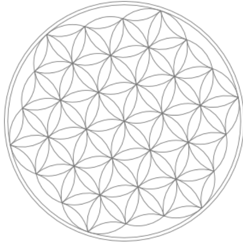
Diet – List what you might eat on a typical day:

Breakfast:

____

____

____



Lunch:

____

____

____

Dinner:

____

____

____

Snacks: (include time of day)

____

How is your appetite? ____

How often do you have a bowel movement? ____

Do you drink coffee? __________ If so, how many cups per day?___________
Do you drink alcohol? _________ If so, how much and how often? ___________
Do you smoke? _____________ If so, how many cigarettes per day? ___________
Do you use recreational drugs? _____________ If so, how often? ____________
How many cups of water do you drink in a day? ______________

What is your typical physical activity in a day?

____

____

____

Are you on a regular exercise program? (Type of activity and frequency)

____

____

____

Mental & Emotional:

Describe the emotional climate of your:
Home Life:

____

____

Work Life:

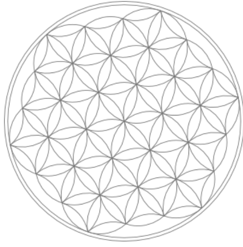
____

____

Social Life:

____

____



When you are under stress, what is your most common emotional response? (Please check all that apply)

□ sadness	□ anger	□ worry	□ other
□ depression	□ fear	□ anxiety	□ ____________

What do you do for relaxation? How often do you actively relax?

____

____

____

How many hours of sleep do you get each night? ___________________________

Do you feel rested when you wake up? ____________________________________

Do you sleep throughout the night? (Y) (N)

If you wake, how many times a night? __________________How long are you awake? ________________________________

Do you work at a computer? _________________________ Do you use a cellphone/smartphone? ______________________

What are your current health goals?

Short term:

____

____

____

Longer term:

____

____

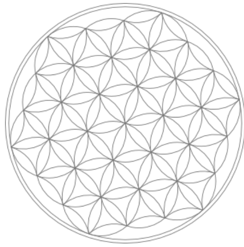
____

What are your expectations from our work together?

____

____

____



LEONURUS

Clinical Herbalism – Plant Medicine
Patient Information and Health History

*Mark **current** symptoms "C"* *Mark **past** symptoms "P"*

General
____ Fatigue
____ Insomnia
____ Disturbed sleep
____ Frequent dreams
____ Excessive sleep
____ Dislike cold
____ Dislike heat
____ Weight loss
____ Weight gain
____ Fever
____ Chills
____ Night sweats
____ Daytime sweating
____ Usually thirsty
____ Seldom thirsty
____ Edema or swelling
Other ____________

Skin
____ Rashes
____ Hives
____ Dry skin
____ Acne
____ Bruise easily
____ Changes in moles
____ Unusual bleeding
Other ____________

Head and Neck
____ Headaches
(location and type of pain)
____ Dizziness
____ Jaw pain
Other ___________

Eyes and Ears
____ Failing vision
____ Blurred vision
____ Visual spots
____ Night blindness
____ Eye pain or redness
____ Ringing in the ears
____ Decreased hearing
____ Ear pain/discharge
Other _____________

Nose, Throat and Mouth
____ Nosebleeds
____ Nasal discharge/ infection
____ Frequent sneezing
____ Sore throat
____ Hoarseness
____ Difficult swallowing
____ Tooth or gum pain
____ Bleeding gums
____ Mouth ulcers
Other ______________

Muscles and Joints
Pain, weakness or numbness in:
____ Neck/shoulder/arm
____ Hips/leg/feet
____ Back & knees
____ Muscle cramps
____ Body pain
____ Heavy limbs
____ Swollen joints
____ Hot joints

Nervous System
____ Fainting
____ Paralysis
____ Tremors
____ Poor balance
____ Seizures
Other _____________

Heart, Lungs & Chest
____ Palpitations
____ Chest pain
____ Chest tightness
____ Rapid heart beat
____ Irregular heart beat
____ Swelling of ankles
____ Cough
____ Dry cough
____ Coughing phlegm
____ Coughing blood
____ Short of breath
____ Asthma/wheezing
____ Frequent colds
____ Pain in rib cage
Other ___________

Mental/Emotional
____ Difficult concentrating
____ Poor memory
____ Worry
____ Anxiety
____ Depression
____ Irritability
____ Frustration or anger
____ Fearfulness
____ Stress
Other ______________

Digestive System
____ Nausea
____ Vomiting
____ Diarrhea
____ Constipation
____ Loose stools
____ Stomach pain
____ Abdominal pain
____ Poor appetite
____ Excessive hunger
____ Abdominal bloating
____ Belching
____ Indigestion
____ Acid reflux
____ Hemorrhoids
____ History of eating disorder

Urinary/Genital
____ Painful urination
____ Difficult urination
____ Frequent daytime
____ Nighttime urination
____ Incontinence
____ Cloudy urine
____ Genital pain or itch
____ Genital discharge
____ Low sex drive
____ Excessive sex drive
____ History of STD __________

Female
____ Irregular periods
____ Painful periods
____ Spotting
____ Passing clots
____ Scanty or no periods
____ Early periods
____ PMS
____ Menopausal symptom
____ Abnormal PAP smear
____ Vaginal discharge
____ Breast lump
____ Breast pain/discharge
Other _______________