Wintergreen Botanicals, LLC
Maria Noël Groves, Clinical Herbalist
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CONFIDENTIAL

Health Inventory
Please Return at Least THREE BUSINESS DAYS Prior to Appointment

Client Name: **Date:**

Address: City: State: Zip:

Phone Number: Email Address (Optional):

Emergency Contact: Phone Number: Relationship:

Height: Weight: Date of Birth:

Primary Health Concerns:

Constitutional Health Intake

Please check the following that apply. Use one check (✓) for mild conditions, two checks (✓✓) for moderate, and three (✓✓✓) checks for frequent or strong conditions. If you have had past problems, mark the line with a "P."

Upper GI

___Mouth frequently too dry
___Occasional foul burps
___Butterflies in stomach
___Often skip or don't finish meals
___Gum &/or teeth problems
___Frequent use of alcohol
___Bitter taste or bad breath in morning
___Excess fullness after eating
___Food feels like it sits in the stomach
___Poor fat digestion
___Food sensitivities
___Food combination problems
___*Frequent canker sores*
___*Smoke to aid digestion*
___*Sometimes excess salivation*
___*Strong demanding hunger*
___*Urge to defecate soon after eating*
___*Enjoy eating all types of foods*
___*Enjoy/prefer eating high protein & fat foods*
___Frequent nausea
___Acid reflux or heartburn
___Ulcer
___Burning pain in stomach or throat

Lower GI

___Frequent constipation
___Often bloated or gassy
___Frequent need for laxatives
___Alternating diarrhea & constipation
___Varicose veins on inner thighs
___Hemorrhoids
___Don't always obey need to defecate
___Often eat too many fats to digest
___Poor sleep after fatty or high protein meal
___*Stools loose with gas*
___*Overly rapid digestion*
___*Loose stools when tired or stressed*
___*Exaggerated rapid a.m. bowel movements*
___*Stools of mixed textures in same movement*
___*Stools resemble toothpaste squeezings*
___Colitis, Crohn's, Inflammatory Bowel Disease
___Diverticulitis
___Irritable Bowel Syndrome (IBS)

Liver

___Dry &/or scaly skin and mucosa
___Hay fever
___Asthma
___Acne on face and buttocks

___Work with solvents or chemicals
___Chemical or spray poisoning
___Excessive or frequent exposure to radiation
___Don't sweat when sick or hot
___Atopic allergies of skin, sinus, bronchial mucosa
___Poor fat &/or protein digestion
___Brown spots, bronzing of skin
___History of viral hepatitis
___*Moist &/or oily skin*
___*Hives from food or drugs*
___*Crave proteins, fats*
___*Sweat freely*
___*Elevated cholesterol*
___*Hypertension*

Kidneys

___Standing too quickly makes you faint, dizzy
___Wake up at night to urinate
___Blush or flush easily
___Water retention or edema
___Moderate low blood pressure
___Frequent thirst
___Craving for salt
___*Standing quickly makes pulse roar in ears*
___*Moderate high blood pressure*
___*Crave fats*
___*Hypertension from salt intake*
___Kidney stones
___Kidney infection

Lower Urinary Tract

___Frequent urination, small amounts
___Sometimes dribble urine after peeing
___Frequent bladder infections (UTIs)
___Demanding and sudden need to urinate
___Mucus in urine
___Dull ache after urination
___Alkaline urine
___Urine usually light colored
___Benign Prostatic Hypertrophy (men)
___*Infrequent urination, copious*
___*Acidic urine*
___*Dark, concentrated urine*
___Difficulty urinating
___Burning urination
___Incontinence
___Interstitial cystitis or prostatitis

Respiratory

___Shortness of breath
___Asthma
___Breathe better when smoking
___Difficulty swallowing mucus
___Rapid, shallow breather
___Sometimes wake up choking or gasping for breath
___Yawn or sigh frequently
___Frequent chest colds
___Frequent lung problems
___Dry membranes with poor expectoration
___*Excess mucus in lungs or throat*
___*Sometimes hyperventilate under stress*
___Tendency toward congestion

Muscular/Skeletal

___Weakness in limbs
___Sore muscles
___Pronounced lethargy after eating
___Osteoporosis or osteopenia
___Bone aches (ie: after exercise)
___*Tight muscles and tendons in neck, back, and legs*
___*Muscles over stimulated when used*
___*Muscles taut at rest*
___*Tight, emotionally guarded muscles in abdomen, arm & shoulder (ie: hiding breasts), or upper back*
___Headaches or migraines
___Osteoarthritis &/or joint pain
___Rheumatoid arthritis
___Lower back pain
___Frequent muscle cramps
___Teeth grinding/TMJ
___ Pain, Type_____

_____

Cardiovascular & Vascular

___Fast, light pulse
___Cold bodied, cold hands/feet
___Sometimes dizzy or faint
___Hypertension, doesn't respond to diuretics
___Skin flushes/blanches with weather or stress
___*Slow, strong pulse*
___*Frequent physical activity*
___*Warm bodied, warm skin/hands/feet*
___*Palpitations in adolescence or before menses*
___*Hypertension that responds to diuretics*
___*High blood viscosity (ie: when giving blood)*
___*General hypertension*
___*High cholesterol*
___*High triglycerides*
___Heart palpitations
___Heart pain or angina
___Varicose veins
___Hemorrhoids
___Frequent nosebleeds
___Bruise easily
___Tendency to anemia

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___High blood pressure
___Low blood pressure
___Congestive heart failure
___History of heart attack(s)
___Other heart condition(s)

Lymphatic & Immune

___Recuperate slowly if sick
___Injuries, bruises heal slowly
___Asthma
___Allergies (seasonal, mold, dust…)
___Chemical sensitivity
___Frequent low-level respiratory infections, colds & flues
___Earaches
___Allergies and hypersensitivities
___Chronic moderate immuno-deficiency
___Auto-immune disease
___Chronic fatigue, Lupus, Lyme, Fibromyalgia, Multiple Sclerosis (circle which one)
___Mononucleosis
___Shingles, Herpes, Cold sores
___Warts
___Constant subtle infections that don't go away
___Candida, yeast, or fungal infections
___ Chronic sinus infections
___Emotional stress that induces depression or frustration
___Digest fats poorly
___*Recuperate quickly if ill*
___*Injuries heal quickly*
___*Digest fats easily*
___Cancer – Type(s)_____

Skin & Mucosa

___Dry skin &/or hair
___Deep skin eruptions, sores
___Cracks, fissures on hands/ feet, slow healing
___Dry, flakey skin problems, rough spots
___Weak, brittle nails
___Frequent mouth, rectal and vaginal sores or inflammation
___Sores, cracks, on mouth, anus, vagina
___Lips often dry, chapped
___Food causes intestinal pain passing through
___Frequent sore throats
___Eczema
___Psoriasis
___Dermatitis or unexplained rashes
___*Skin eruptions superficial, come to a head*
___*Oily skin, scalp or hair (not just face)*
___*Acne*
___*Thick membranes (ingrown hair, sebaceous cysts)*
___*Radiate body heat*
___*Strong body scent*

Male ~ Reproductive

___Frequent cannabis use
___Pain or ache after orgasm
___BPH/Enlarged prostate (before age 45)
___Difficult maintaining erection even if you are in the mood
___Low sperm count
___Decreased sexual desire
___*Sweat freely with strong scent*
___*Oily skin, facial acne*
___*Recent increases in skin, scalp oiliness*
___*Regular alcohol consumption*

Female ~ Reproductive

___Crave sweets & carbohydrates
___Cycle more than 28 days
___Water retention before menses in hands/feet
___Crave sweets before menses usually
___Miss some periods, erratic cycles
___Menses slow starting with cramps
___Menses with spotting that lasts too long
___Menstruation lengthy
___Menstruation with frequent cramps
___Frequent Class II Pap smears
___History of PID, cervicitis, HPV
___Miscarriages, problem pregnancy
___Period late with altitude change
___Tried but couldn't handle birth control pills
___Frequent candida-type infections
___Vaginal and/or uterine inflammation
___Cervical erosion
___History of class 2 &3 PAPs
___Feel better in the first half of cycle (Day 1/period-14/ovulation)
___Decreased sexual desire
___*Sweat freely with strong scent*
___*Oily skin, facial acne*
___*Cycle less than 28 days*
___*Water retention before menses in hips & breasts*
___*Often crave fat and protein before menses*
___*Sides of breasts tender before menses*
___*Menstruation short, defined w/ few cramps*
___*Period early with altitude change*
___*Feel better in the last half of cycle (Day14/ovulation-28/period)*
___*Regular cannabis or alcohol use*
___Menopause symptoms
___Crave chocolate

Metabolic & Endocrine Systems

___Use artificial sweeteners (aspartame, Splenda)
___Frequent dieting

___Eating disorder (bulimia, anorexia)
___Frequent or compulsive overeating
___Can't gain weight
___Can't lose weight
___Diabetes, Type 1
___Diabetes, Type 2 (adult onset)
___Insulin resistance (Syndrome X, Metabolic disorder)
___Blood sugar wobbles (ie: hypoglycemia)
___Eat or else faint/nervous
___Enjoy hot weather
___Enjoy cold weather
___Enjoy humid/damp weather
___Hyperthyroid or borderline high thyroid
___Hypothyroid or borderline low thyroid
___Adrenal-related disorder (ie: Addison's)

Nervous System & Emotional Health

___Often sluggish
___Often over-energized, hyperactive
___Can't get started without coffee
___Like stimulants (caffeine, uppers)
___Like downers/depressants
___Awaken, can't go back to sleep (insomnia)
___ Bad dreams
___Difficulty falling asleep (insomnia)
___Sleep too much
___Sleep too little
___Anxiety
___Panic attacks
___Obsessive Compulsive Disorder or tendencies
___Post Traumatic Stress Disorder
___Depression
___Loneliness
___Sadness, easy crying
___Easily angered, frustrated
___Poor concentration &/or ADD/ADHD
___Sensitivity to alcohol (allergy or addiction)
___Drink more than 2 drinks/night or 14 drinks/week
___Alcoholism (past or present?)
___Drug addiction or abuse
___Smoker
___Addictive tendencies
___Facial twitches
___Tremors in hands or neck
___Seizures
___Lack of muscle control
___Lack of sensation somewhere in the body
___Ringing in ears (tinnitus)

Vision & Microcirculation

___Macular degeneration
___Glaucoma
___Cataracts
___Night blindness
___Impaired or blurry vision
___Impaired hearing
___Memory loss

ADDITIONAL INFORMATION

Please list any pharmaceutical drugs you take on a regular basis with amounts, how long you are taking them, and why.
Feel free to use a separate sheet if necessary.

Drug	Dose/Per Day	Length of Time	Why

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Please list any herbs, supplements, and vitamins you take on a regular bases with amounts, how long you are taking them, and why.
Feel free to use a separate sheet if necessary.

Supplement/Herb	Form	Dose/Per Day	Length of Time	Why

MEDICAL HISTORY
Past surgeries:

Do you have any allergies to pharmaceuticals or other substances?

Food allergies or sensitivities?

Family History of Disease?

LIFESTYLE
Exercise: How many hours/week?
What forms?
Relaxation: How many hours/week?
What forms?
Sleep: How many hours/night? Quality?
Work: What do you do for a living?
How many hours/week?
Do you enjoy it?
Home & Life: What is your home situation?
Children & ages:
Members of your household:
How are you connected with your community & extended family?

Are you satisfied by your relationships?
Spirit: Are you spiritual?
In what ways do you find spiritual solace?

How do you feel emotionally?

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DIETARY INFORMATION

If possible, please keep a food diary for three days and include it with your intake form.

General Dietary Info:

What kinds of snacks do you eat?

How often do you snack?

What do you drink?

Typical breakfasts?

Typical lunches?

Typical dinners?

How Many Servings per Day of:	
Vegetables	Fruit
Protein	(what forms of protein?)
Sweets	Artificial Sweeteners
Whole Grains	Baked Goods
Processed Foods	Eat Out
Alcohol	Caffeine (coffee, chocolate, tea)
How much water per day?	**Daily Calorie Intake?**

What therapies have you tried for your primary health concerns that did NOT work or with which you experienced side effects?

Is there anything you'd like to add to this intake?