

Michele's Garden

*Translating Ancient Natural Health
Traditions and Old World Culinary Customs
to bring about Health and Balance*

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HOLISTIC CHEF HERBALIST INSTRUCTOR

Herbal and Nutritional Consulting
Client Instructions and Correspondence

HEALTH INVENTORY

Date _____

Name _____ Age _____ Birth date _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Height _____ Weight _____ 1 year ago _____ 5 years ago _____

Occupation: _____ Full time _____ or Part time _____

Living situation: Alone Friends Partner Spouse Parents Children Pets

Names and ages of those living with you: _____

What are your major health concerns and intentions for your visit today?

Please list any other health care providers or consultants you are currently working with:

Would you like any of them to receive a copy of your recommendations?

Please list all herbs, vitamins, and dietary supplements you currently take, citing brand name whenever possible (use additional space on back if needed):

PRODUCT	DOSAGE	FREQUENCY (NUMBER/DAY)
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List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or Prescribed (P). Use additional space on back if needed.

PRODUCT	OTC or P?	DOSAGE	FREQUENCY (NUMBER/DAY)
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List all medications, herbs, etc., to which you have a known allergy:

DIETARY INFORMATION

Describe below your typical meals. Be specific. For example, instead of "oil," list type of oil, such as olive, corn, etc. Instead of "bread," list whether white or whole grain, etc. Instead of "vegetables," list the type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include all beverages, type and quantity (two cups of coffee, one glass of orange juice, etc.):

Breakfast: _____

Morning snack(s): _____

Lunch: _____

Afternoon snack(s): _____

Dinner: _____

Daily water consumption (number of glasses per day): _____

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.):

Please list any known food allergies/sensitivities:

FOOD

DESCRIBE REACTION

Typical times of meals and snacks:

FAMILY HISTORY

Describe any relevant or major health related issues (alcoholism, high blood pressure, cancer, diabetes, heart disease, psychiatric illness, osteoporosis, other addictions, other illnesses):

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Other family members with pertinent issues, or recurring family health trends:

PAST HEALTH PROBLEMS

List all major health problems including any operations:

PROBLEM

YEAR

GENERAL

Mark all that apply. If mild, mark "1"; if strong, mark "2".

- | | |
|---|---|
| <input type="checkbox"/> Awakens, can't go back to sleep | <input type="checkbox"/> Increase in weight (recent) |
| <input type="checkbox"/> Bad dreams | <input type="checkbox"/> Lack of sensation somewhere |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Likes depressants |
| <input type="checkbox"/> Brown spots, bronzing of skin | <input type="checkbox"/> Likes stimulants |
| <input type="checkbox"/> Bruises easily | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Can't gain weight | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Can't lose weight | <input type="checkbox"/> Nails split, brittle |
| <input type="checkbox"/> Can't get started without coffee | <input type="checkbox"/> Nose bleeds frequently |
| <input type="checkbox"/> Chemical or spray poisoning | <input type="checkbox"/> Pollution heavy in environment |
| <input type="checkbox"/> Chronic fatigue, depression | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Cries easily without apparent cause | <input type="checkbox"/> Pulse speeds up after meals |
| <input type="checkbox"/> Depressed for long periods | <input type="checkbox"/> Sensitive to cold weather |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Sensitive to hot weather |
| <input type="checkbox"/> Eat often or else faint/nervous | <input type="checkbox"/> Sensitive to high humidity |
| <input type="checkbox"/> Eyes often red/inflamed | <input type="checkbox"/> Sensitive to low humidity |
| <input type="checkbox"/> Face, eyes get puffy | <input type="checkbox"/> Sexual desire decreased |
| <input type="checkbox"/> Facial twitches | <input type="checkbox"/> Sexual desire increased |
| <input type="checkbox"/> Gum problems | <input type="checkbox"/> Stuffy nose during the day |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stuffy nose in evening/night |
| <input type="checkbox"/> Headaches in morning, wearing off | <input type="checkbox"/> Tendency to anemia |
| <input type="checkbox"/> Heart palpitations when hungry | <input type="checkbox"/> Tremors in hands or neck |
| <input type="checkbox"/> Heart palpitation after eating | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Highly emotional | <input type="checkbox"/> Highly controlled |
| <input type="checkbox"/> Weight gain in upper arms, shoulders, back of neck | <input type="checkbox"/> Impaired hearing |

CARDIOVASCULAR

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Pain in heart | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Stroke/murmur |
| <input type="checkbox"/> Fast, light pulse | <input type="checkbox"/> Slow, strong pulse |
| <input type="checkbox"/> Cold bodied | <input type="checkbox"/> Warm bodied |
| <input type="checkbox"/> Sometimes dizzy or faint | <input type="checkbox"/> Frequent physical activity |
| <input type="checkbox"/> Hands cold, clammy or dry | <input type="checkbox"/> Hands warm, sweaty |
| <input type="checkbox"/> Hypertension, not responding to diuretics | <input type="checkbox"/> Hypertension responds to diuretics |
| <input type="checkbox"/> Palpitations either as an adolescent or before menses | |

SKIN

- | | | |
|---|--|---|
| <input type="checkbox"/> Boils | <input type="checkbox"/> Bruises | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Itching | <input type="checkbox"/> Skin on trunk is dry |
| <input type="checkbox"/> Oily scalp or hair | <input type="checkbox"/> Dry scalp or hair | |
| <input type="checkbox"/> Skin eruptions are deep, not coming to a head | | |
| <input type="checkbox"/> Skin eruptions are superficial, come to a head | | |
| <input type="checkbox"/> Cracks, fissures on heel, elbow, feet, heal poorly | | |

MUSCLES/JOINTS

- | | | |
|------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Backache | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Mobility |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Weakness |

UPPER GI

- | | |
|---|---|
| <input type="checkbox"/> Sometimes nausea in evenings | <input type="checkbox"/> Sometimes nausea in mornings |
| <input type="checkbox"/> Mouth frequently too dry | <input type="checkbox"/> Sometimes excess salivation |
| <input type="checkbox"/> Duodenal ulcer | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Sometimes foul burps | <input type="checkbox"/> Strong, demanding hunger |
| <input type="checkbox"/> Butterflies in stomach | <input type="checkbox"/> Seldom eat breakfast |
| <input type="checkbox"/> Often don't finish meals | <input type="checkbox"/> Often eat to calm down |
| <input type="checkbox"/> Receding gums | <input type="checkbox"/> Frequent use of alcohol |
| <input type="checkbox"/> Frequent poor appetite | <input type="checkbox"/> Bitter taste in morning |
| <input type="checkbox"/> "Dragon breath" in morning | <input type="checkbox"/> Acid indigestion at night |
| <input type="checkbox"/> Frequent mouth cold sores | <input type="checkbox"/> Sometimes difficulty in swallowing |
| <input type="checkbox"/> Indigestion after eating | |

LOWER GI

- | | |
|---|---|
| <input type="checkbox"/> Constipation with gas | <input type="checkbox"/> Stools loose with gas |
| <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Digestion unusually rapid |
| <input type="checkbox"/> Light colored, hard stools | <input type="checkbox"/> Loose stools when tired/stressed |
| <input type="checkbox"/> Intestines often bloated | <input type="checkbox"/> Dark, soft stools |
| <input type="checkbox"/> Constipation with hemorrhoids | <input type="checkbox"/> Quick defecation after eating |
| <input type="checkbox"/> Constipation with painful defecation | <input type="checkbox"/> Constipation w/fully formed stools |
| <input type="checkbox"/> Constipation w/hard, marbly stools | <input type="checkbox"/> Tongue often coated |

LIVER

- | | |
|--|--|
| <input type="checkbox"/> Dry, even scaly skin | <input type="checkbox"/> Moist, sometimes oily skin |
| <input type="checkbox"/> Hay fever or asthma | <input type="checkbox"/> Hives from food or drugs |
| <input type="checkbox"/> Craves fruit or sweet | <input type="checkbox"/> Craves proteins, fats |
| <input type="checkbox"/> Frequent trouble digesting fats | <input type="checkbox"/> Fever with sweat when sick |
| <input type="checkbox"/> Acne on face AND buttocks | <input type="checkbox"/> Seem to have low blood sugar |
| <input type="checkbox"/> Had hepatitis in past | <input type="checkbox"/> Frequent use of alcohol |
| <input type="checkbox"/> Work with solvents | <input type="checkbox"/> Psoriasis, eczema, dermatitis |
| <input type="checkbox"/> Frequent minor illnesses | <input type="checkbox"/> Don't sweat when sick |

RENAL

- | | |
|--|---|
| <input type="checkbox"/> Standing too quickly causes faintness/dizziness | <input type="checkbox"/> Frequent water retention |
| <input type="checkbox"/> Standing too quickly makes pulse roar in ears | <input type="checkbox"/> Urine usually dark |
| <input type="checkbox"/> Frequent flushing or blushing | <input type="checkbox"/> Moderate high blood pressure |
| <input type="checkbox"/> Moderate low blood pressure | <input type="checkbox"/> Craving for salt |
| <input type="checkbox"/> Frequent thirst | <input type="checkbox"/> Wakes up at night to urinate |
| <input type="checkbox"/> Urine always light colored | |

LOWER URINARY TRACT

- | | |
|--|--|
| <input type="checkbox"/> Frequent urination, small amounts | <input type="checkbox"/> Infrequent urination, copious |
| <input type="checkbox"/> Sometimes dribble afterwards | <input type="checkbox"/> Frequent bladder infections |
| <input type="checkbox"/> Demanding need to urinate | <input type="checkbox"/> Mucus in urine |
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> Dull ache after urination |

REPRODUCTIVE

- | | | |
|--|--|---|
| MEN | | |
| <input type="checkbox"/> Frequent cannabis user | <input type="checkbox"/> Pain or ache after orgasm | |
| <input type="checkbox"/> Difficult maintaining erection when in the mood | <input type="checkbox"/> Benign prostatic hypertrophy | |
| WOMEN | | |
| <input type="checkbox"/> Cycle more than 28 days | <input type="checkbox"/> Cycle less than 28 days | |
| <input type="checkbox"/> Miss some periods | <input type="checkbox"/> Water retention before menses | |
| <input type="checkbox"/> Menses slow starting with cramps | <input type="checkbox"/> Menstruation always lengthy | |
| <input type="checkbox"/> Constipation before, loose stools after menses starts | <input type="checkbox"/> Always hungry before menses | |
| <input type="checkbox"/> Frequent Class II Pap smear | <input type="checkbox"/> Breasts tender before menses | |
| <input type="checkbox"/> History of PID, cervicitis | <input type="checkbox"/> Palpitations before menses | |
| <input type="checkbox"/> Miscarriages, problem pregnancy | <input type="checkbox"/> Period early with altitude change | |
| <input type="checkbox"/> Period late with altitude change | <input type="checkbox"/> Hot flushes | |
| <input type="checkbox"/> Tried, but couldn't take birth control pills | | |
| Contraceptive/Pregnancy History | | |
| <input type="checkbox"/> BC Pills | <input type="checkbox"/> Rhythm | <input type="checkbox"/> IUD |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Condoms | <input type="checkbox"/> Mucous method |
| <input type="checkbox"/> Cervical Cap | <input type="checkbox"/> Spermicides | <input type="checkbox"/> Fertility lens |

Please list each pregnancy you have had, including miscarriages and abortions:

RESPIRATORY

- | | |
|---|--|
| <input type="checkbox"/> Shortness of breath when standing or walking | <input type="checkbox"/> Slow, strong pulse |
| <input type="checkbox"/> Tobacco smoker | <input type="checkbox"/> Sometimes hyperventilates |
| <input type="checkbox"/> Difficulty swallowing mucus | <input type="checkbox"/> Rapid, shallow breather |
| <input type="checkbox"/> Yawns frequently | <input type="checkbox"/> Frequent chest colds |
| <input type="checkbox"/> Sometimes wakes up choking or gasping for breath | |

MUCUS

- | | |
|---|--|
| <input type="checkbox"/> Sores, cracks, fissures in mouth, anus, vagina | <input type="checkbox"/> Lips often dry, chapped |
| <input type="checkbox"/> Food often causes intestinal distress as it passes | <input type="checkbox"/> Gets sore throat easily |

LYMPHATIC

- | | |
|--|---|
| <input type="checkbox"/> Recuperates slowly if ill | <input type="checkbox"/> Recuperates quickly if ill |
| <input type="checkbox"/> Injuries heal slowly | <input type="checkbox"/> Injuries heal quickly |
| <input type="checkbox"/> Eczema, dermatitis | <input type="checkbox"/> Asthma or hay fever |
| <input type="checkbox"/> Arthritis or rheumatism | |

CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING

Take time to think about and answer the following questions:

Are you completely satisfied with your living conditions?

Are you able to express your feelings and emotions?

Is there an excess of stress in your life? What is causing the stress?

Are you satisfied with your job?

If in a relationship, are you satisfied with it? Are you lonely?

Is there something you would like to change in your life? Can you change it?

Are you a "nervous type" of person? What sorts of things make you nervous?

Do you sleep well? How many hours (in a 24-hour period)?

Do you dream? Do you remember your dreams?

Are you satisfied with your energy level? Do you often feel exhausted?

Is it easy to wake up in the morning? Do you enjoy your work?

