CONSULTATION FORM

CONSULTATION FORM to be filled out 48hrs before consult.
Please fill in form or document for client to print out and scan back to the email: pollysherbalfix@aol.com

Provide the following by email if appropriate:

☐ Most recent CBC blood work panel and other lab results if relevant to your health issues. ***PLEASE NOTE:*** *Extensive lab reports can be time-consuming to review and can eat up your time with the herbalist. Therefore, she will need to spend additional time reviewing and charting labs. For that reason, more than 8 pages of labs will incur an additional lab review fee of $45.* To avoid this fee, place the pertinent information from each lab test in an excel spread sheet. Or you can simply explain the results from each category of tests in a narrative. (Example: Thyroid tests: On 01/15/18 my TSH was 15. My last TSH test, on 04/01/2020 was 2.4) etc.
Please call if you have any additional questions.

POLICIES AND PROCEDURES

- If ZOOM, or phone appointment, please email this intake form to us at least 24 hours in advance of your scheduled appointment.

INITIAL CONSULT - WHAT YOU SHOULD EXPECT

30 minutes of your appointment time reviewing your Intake Form and starting a protocol outline for you. The more complex your history and labs, the longer it will take. Will make nutritional, dietary, lifestyle and other recommendations. You will receive a written protocol, which includes the name and recommended dose of each herbal and nutritional compound.

YOUR PROTOCOL

Dietary and lifestyle changes are essential to true healing and to facilitate the therapeutic response of the natural compounds and herbs. She may recommend exercise, dietary changes or other types of therapy, such as acupuncture or counseling, which may be helpful. The types of things recommended are determined by your current health, constitutional evaluation, and your interest.

Polly's Herbal Fix is very particular and uses only high-quality alkaline products with which she sees consistent, good therapeutic results. Many of these compounds are not found in health food stores as they are sold to practitioners only. With this consistency in product quality and potency, better results are seen in short amount of time

Usually, a given protocol is followed for 1 to 3 months. For optimal results, you may need to be reassessed at that time so that appropriate changes can be made to the herbal formulation and nutritional protocol.

CLIENT DISCOUNTS

Following your appointment, you are eligible to receive discounts on many of our products. These discounts are available on the day of the appointment.

CANCELLATION POLICY

- If you need to reschedule or cancel your appointment, please notify the office with at least 24 hours advance notice to avoid a cancellation fee.

Be advised that you will be charged $20 for a new consult, if you cancel with less than 24 hours' notice.

- Thank you for your consideration of the practitioner's time and of others waiting for appointments.

☐ ______________________________

By placing an "x" in the box above and entering your name, you agree to the Cancellation Policy.

INFORMED CONSENT FORM

My purpose is simply to educate my client and/or student and his or her body as to healing by natural processes. I consider herbs and foods to be nutritional assets to health and it is in this way that I offer my advice. Although I personally believe herbs are a part of good health care, I make no claims for their medicinal actions. Any information offered is done so on the basis of research and scientific evidence and traditional uses.

My clients/students agree to make their own choices as to what they do with the educational material they have been offered and are solely responsible for their own decisions and actions. It is always my suggestion that the client/student should seek out the advice of a licensed health care practitioner whenever they feel it is necessary in regard to their own personal health.
I have read the above statement and I understand and agree with it. My purpose to seeking the advice of Polly's Herbal Fix is done so for educational and nutritional purposes only.

☐ __________________________________

By placing an "x" in the box above and entering your name, you agree to the Cancellation Policy.

PERSONAL HEALTH PROFILE
"*If you are not ready to alter your way of life, you cannot be healed…*" Hippocrates

Name: ____ Age: ________ Weight: __________ Number and ages of children: ___________________

Phone #: (HOME) ____________________________ (CELL) ____________________________
Preference: ☐ Home ☐ Cell

Full address: ____

E-mail Address: ____________________________ Referred by: ____________________________

Date of Initial Appointment: __________________ Day of Week: Tue or Wed______ Time: 3pm 4pm 5pm 6pm (all AZ time)_________

KEY AREAS OF PHYSICAL CONCERN: In this section, list your main physical complaints on the lines below and rate them by severity **on a scale of 1-10, with 10 being the most severe.** Where is this issue currently?

Health Issue	Severity

Have you seen any doctors or other therapists regarding the above health issues? If yes, please list below:

Practitioner Name(s)

HEALTH STATUS:
Check each column below where symptoms apply.

x = sometimes experience **x x = occurs often** **x x x = major concern**

Cardiovascular	
☐☐☐ High blood pressure	☐☐☐ Previous stroke
☐☐☐ Low blood pressure	☐☐☐ Cold hands/feet
☐☐☐ Pain upper left chest	☐☐☐ Tingling arms/hands
☐☐☐ Poor circulation	☐☐☐ High cholesterol
☐☐☐ Swelling ankles/joints	☐☐☐ Poor cholesterol ratios
☐☐☐ Heart Palpitations	☐☐☐

x = sometimes experience x x = occurs often x x x = major concern	
Muscles/Joints	
☐☐☐ Backache upper/lower	☐☐☐ Rheumatoid arthritis
☐☐☐ Broken bones past/present	☐☐☐ Stiffness in joints
☐☐☐ Osteoarthritis	☐☐☐

x = sometimes experience x x = occurs often x x x = major concern	
Eyes, Ears, Nose & Throat	
☐☐☐ Ear aches	☐☐☐ Hearing loss
☐☐☐ Eye pains, dry/teary	☐☐☐ Excessive ear wax
☐☐☐ Failing/worsening vision	☐☐☐

x = sometimes experience x x = occurs often x x x = major concern	
Urinary/Kidney	
☐☐☐ Excessive urination	☐☐☐ Up to urinate 1x night
☐☐☐ Water retention	☐☐☐ Up to urinate 2x's night
☐☐☐ Kidney stones past/present	☐☐☐ Burning urination
☐☐☐ Lower back stiffness/soreness	☐☐☐ Dark, cloudy urine
☐☐☐ Dark circles under eyes	☐☐☐

x = sometimes experience x x = occurs often x x x = major concern	
Skin	
☐☐☐ Boils	☐☐☐ Cysts
☐☐☐ Bruises	☐☐☐ Pimples
☐☐☐ Dryness	☐☐☐ Sores
☐☐☐ Itching	☐☐☐ Broken veins
☐☐☐ Varicose veins	☐☐☐

x = sometimes experience x x = occurs often x x x = major concern	
Respiratory	
☐☐☐ Difficulty breathing	☐☐☐ Sinus infections
☐☐☐ Cough	☐☐☐ Asthma attacks

☐☐☐ Sinus congestion	☐☐☐ Post nasal drip
☐☐☐ Frequent colds	☐☐☐ Sore throat
☐☐☐ Emphysema	☐☐☐

x = sometimes experience x x = occurs often x x x = major concern	
Gastrointestinal	
☐☐☐ Belching	☐☐☐ Indigestion
☐☐☐ Colitis	☐☐☐ 1 bowel movement/day
☐☐☐ Constipation	☐☐☐ 2 bm/day
☐☐☐ Hepatitis	☐☐☐ 1 bm/every other day
☐☐☐ Gallstones	☐☐☐ 2 or less bm/week
☐☐☐ Ulcers	☐☐☐ Blood in stools
☐☐☐ Abdominal pain	☐☐☐ Light colored stools
☐☐☐ Abdominal cramps	☐☐☐ Black, tarry stools
☐☐☐ Burning esophagus	☐☐☐ Frequent diarrhea
☐☐☐ Gas	☐☐☐

x = sometimes experience x x = occurs often x x x = major concern	
Other	
☐☐☐ Memory problems	☐☐☐ Uncomfortable in moldy, damp rooms
☐☐☐ Dizziness	☐☐☐ Toenail fungus
☐☐☐ Crave sweets, breads or alcohol	☐☐☐ Sensitive to tobacco, chemical odors, perfume
☐☐☐ Athlete's foot, jock rash	☐☐☐ Tongue coated heavy white/yellow in a.m.

Allergies		
Do you have allergies?	☐No	☐Yes, to what?
Medication or herb allergies	☐No	☐Yes, to what?
Food allergies	☐No	☐Yes, to what?
History		
Have you had any operations?	☐No	☐Yes, list with dates
Any major injuries/accidents?	☐No	☐Yes, list with dates

Supplements *(if you have more supplements than will fit on this form, please email a separate page)*

Name of supplement	Dosage	Used for what purpose?

Medications

Name of medication	Dosage	Used for what purpose?

Common Physical Activities		
☐ Sitting at Desk (how long)		☐ Walking
☐ Sitting in a car (how long)		☐ Yoga
☐ Standing (how long		☐ Tao Chi
☐Jogging/running (times per week)		☐ Hiking
☐ Aerobics		☐ Bike riding
☐ Swimming		☐ Horseback riding
☐ Weight-lifting		☐ Tennis
Do any of the above activities aggravate a current health condition?	☐No	☐Yes, explain

Dietary Habits	
☐ Canned Foods	☐ Raw vegetables
☐ Fresh vegetables	☐ Cooked veggies

☐ Red meat/non-organic	☐ Desserts
☐ Red meat/organic or game	☐ Coffee (cups (not mugs)/day)
☐ White sugar	☐ Black tea (cups (not mugs)/day)
☐ Stevia	☐ Wine (cups/day)
☐ Honey	☐ Other alcohol (cups/day)
☐ Sweet and Low, nutrasweet, etc	☐ Cigarettes: /day
☐ Soft drinks w/ sugar: /day	☐ Salt (list type)
☐ Soft drinks w/ nutrasweet: /day	☐ Soy
☐ Butter	☐ Kombucha; quantity per day
☐ Margarine	☐ Kefir or fermented food; quantity per day
☐ Fruits, fresh	☐ Coconut oil
☐ Fruits, canned	☐ Olive Oil
☐ Canola, Wesson, Vegetable or Soy Oil	☐ Other Oils? enter type:
☐ Bread; number of slices per day: /day Type:	☐ Nuts. Quantity is 1 Tablespoon? ¼ cup? ½ cup? More?
☐ Crackers; number of crackers per day: /day	☐ Gluten-free breads: /day)
Gluten-free crackers: /day)	☐ Chips; number of chips per day: /day ☐

Do you drink filtered water or tap water? ☐ Filtered ☐ Tap Type of filter:

If you use a filter, what type and/or conditioner do you use?

If delivered or purchased, is it distilled or reverse osmosis?

How much water do you drink on a regular basis?

3-Day Diet Journal:

List a typical day's meals:

Time	Day 1 Food – **Date**	Beverage(s)
	Breakfast	
	Snack	
	Lunch	
	Snack	
	Dinner	
	Desserts	

Time	Day 2 Food – **Date**	Beverage(s)
	Breakfast	
	Snack	

	Lunch	
	Snack	
	Dinner	
	Desserts	

Time	Day 3 Food – **Date**	Beverage(s)
	Breakfast	
	Snack	
	Lunch	
	Snack	
	Dinner	
	Desserts	

Family History:

Check any significant immediate family health history:

Family History	
☐ Diabetes	☐ Heart conditions
☐ Asthma	☐ Epilepsy
☐ Cancer	☐ Mental illness
☐ Gout	☐ Thyroid problems
☐	☐

For Men Only	
☐ Frequency of urination	☐ Swollen prostrate
☐ Hesitancy when urinating	☐ Painful urination
☐ Difficulty getting/maintain erection	☐ Benign Prostatic Hyperplasia

For Women Only	
☐ Used birth control? How long	☐ Hot flashes
☐ Used hormone replacement therapy. How long	☐ Difficultly conceiving
☐ Uterine fibroids	☐ Dramatic mood swings
☐ Uterine cysts	☐ Pounding heart
☐ Endometriosis	☐ Dry vaginal lining
☐ Cervical dysplasia	☐ Osteoporosis
☐ Pelvic pain. How long?	☐ Painful menstrual cramps
☐ Painful intercourse	☐ Absence of menstrual cycle
☐ Genital herpes	☐ Dramatic mood swings around cycle

☐ Vaginal infection (type)	☐ Irregular menstrual cycles
☐ Breast pain, related to cycle?	☐ Headaches (how frequent)? Last?
☐ Breast lumps, change with cycle?	☐ Vaginal discharge (diagnosed)?
☐ Pelvic Inflammatory disease	☐ Vaginal infection (type)
☐ Break through bleeding or spotting between periods	☐ Heavy menstrual bleeding during period

Emotional Checklist – L-T Put an X next to each statement that corresponds to the way you often feel. Put 2 X's next to the statement if you "see yourself" in that statement, meaning you recognize those feelings or thoughts often.
☐ ☐ Anxiety, especially anxiety in the head, ruminating thoughts etc.
☐ ☐ Panic attacks or phobias
☐ ☐ Feeling worried or fearful
☐ ☐ Obsessive thoughts or behaviors
☐ ☐ Perfectionism or being overly controlling
☐ ☐ Irritability
☐ ☐ Anxiety that's worse in winter
☐ ☐ Winter blues or seasonal affective disorder
☐ ☐ Negativity or depression
☐ ☐ Suicidal thoughts
☐ ☐ Excessive self-criticism

Emotional Checklist – LT (Cont'd) Put an X next to each statement that corresponds to the way you often feel. Put 2 X's next to the statement if you "see yourself" in that statement, meaning you recognize those feelings or thoughts often.
☐ ☐ Low self-esteem and poor self-confidence
☐ ☐ PMS or menopausal mood swings
☐ ☐ Sensitivity to hot weather
☐ ☐ Hyperactivity
☐ ☐ Anger or rage
☐ ☐ Digestive issues
☐ ☐ Fibromyalgia, temporomandibular joint syndrome, or other pain syndromes
☐ ☐ Difficulty getting to sleep
☐ ☐ Insomnia or disturbed sleep
☐ ☐ Afternoon or evening cravings for carbs, alcohol or drugs

Emotional Checklist – L-Ty

Put an X next to each statement that corresponds to the way you often feel. Put 2 X's next to the statement if you "see yourself" in that statement, meaning you recognize those feelings or thoughts often.
☐ ☐ Depression and apathy
☐ ☐ Easily bored
☐ ☐ Lack of energy
☐ ☐ Lack of focus
☐ ☐ Lack of drive and low motivation
☐ ☐ Attention deficit disorder
☐ ☐ Procrastination and indecisiveness
☐ ☐ Craving carbs, alcohol, caffeine, or drugs for energy

Emotional Checklist – L-Ph Put an X next to each statement that corresponds to the way you often feel. Put 2 X's next to the statement if you "see yourself" in that statement, meaning you recognize those feelings or thoughts often.
☐ ☐ Heightened sensitivity to emotional pain
☐ ☐ Heightened sensitivity to physical pain
☐ ☐ Crying or tearing up easily
☐ ☐ Eating to soothe your mood, or comfort eating
☐ ☐ Really, really *loving* certain foods, behaviors, drugs, or alcohol
☐ ☐ Craving a reward or numbing treat

Emotional Checklist – L-GL Put an X next to each statement that corresponds to the way you often feel. Put 2 X's next to the statement if you "see yourself" in that statement, meaning you recognize those feelings or thoughts often.
☐ ☐ Crave sugar, starch or alcohol any time during the day
☐ ☐ Irritable, shaky, headachy – especially if too long between meals
☐ ☐ Intense cravings for sweets
☐ ☐ Lightheaded if meals are missed
☐ ☐ Eating relieves fatigue
☐ ☐ Agitated, easily upset, nervous

Additional history with dates or other health related issues you wish to mention: