**Miracle Herbal Clinics LLC.**

Please complete this form to the best of your ability. If you feel that you don’t want to disclose certain information, that is your choice, but it can affect our work together. All information is kept confidential and private. Please sign attached waiver and privacy statements.

Name:

Address:

Phone: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ (Home)

\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ (Work)

\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ (Cell)

Email:

Occupation:

Gender: Female Male

Age: \_\_\_\_\_\_\_\_\_\_ Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_\_

Married \_\_\_\_\_\_ Single \_\_\_\_\_\_\_ Divorced \_\_\_\_\_\_\_\_\_\_ Partnership \_\_\_\_\_\_\_\_\_

How is your relationship?

Number of Children: \_\_\_\_\_\_\_\_\_\_\_ Ages of Children:

Are you currently breastfeeding or Pregnant? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Are you trying to become Pregnant? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Reasons for your visit:

Primary Complaint:

Where on your body are you experiencing pain?

What is the duration of the pain?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The complaint is often accompanied by:

History of Complaint:

Past Medical History (Childhood illnesses, hospitalizations, trauma, etc.):

Major Illnesses:

Past Surgeries:

Pregnancies:

How was your birth experience?

Any abortions or miscarriages?

List all allergies:

Describe any significant accidents:

List all medications (supplements, herbs, prescription and over-the-counter drugs) you are currently taking:

Are there any ailments such as Diabetes, High Blood Pressure or Cancer in your family? If so, please describe them and their relation to you. Feel free to put down as much information as you wish, it is all valuable to your health work up.

Do you consume caffeine? If so, how much?

Do you smoke? How many cigarettes per day?

Do you consume Alcohol? How much per day?

Do you use recreational or habit sustaining drugs (such as heroin, marijuana, cocaine, etc.)?

How much red meat do you consume per week?

How much fish or shellfish do you consume per week?

How much fowl do you consume per week?

Are you Vegan or Vegetarian?

If female how is your menstrual cycle?

How are your energy levels?

Are you willing to keep a food diary? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Daily Exercise, what and how much?

If you had to rate your stress levels on a scale of 1 to 10 (with 10 being the highest), how do you rate your daily life?

How many hours a sleep do you get per day?

How would you describe your sleep?

Circle any of your current symptoms and add anything you feel is pertinent:

Nervous System:

Stress

Worries

Headaches

Migraines

Dizziness, Fainting

Hearing

Vision

Pins and Needles

Muscular Skeletal Systems:

Joint Pain

Osteoarthritis

Rheumatoid Arthritis

Gout

Edema

Weakness

Broken Bones

Balance

Endocrine System:

Height and Weight

Body weight distribution

Adrenals

Thyroid

Sweating Tremors

Reproductive System:

Blood Clots

Breast Health

Menarche

Cramps (explain occurrences)

PMS

Birth Control

Ovulation

Menopause

Prostate issues

Incontinence

Infections

Yeast Infections

Venereal Diseases

Digestive System:

Stools (mucus present, dry, hard, liquid, color, etc.)

How many bowel movements per day?

Gas

Hemorrhoids

Cravings

Appetite

Vomiting

Heart Burn

Bad Breath

Bloating

Respiratory System:

Cough

Coughing mucus/blood

Phlegm (if so, what color)

Bronchitis

Pneumonia

Asthma

Painful Breathing

Skin:

Coloration

Temperature

Rashes

Acne

Dandruff

Rosacea

Urinary System:

Frequency of urination

Impotence

Difficulty stopping or starting flow

Kidney Stones

Blood in Urine

Irregular Flow

Urgency of urination

Are there any issues you wish to discuss?

Do you have any other health issues?

Do you have any emotional issues?

Other Health Concerns:

Anything else that you feel is essential to our work together (emotional complaints, etc.)?

Amount of TV/Computer time per day?

Types of cleaning products used (detergents, Etc.)