

Cabrera Consultants

Innisfree Farm, 3636 Trent Road, Courtenay, BC, V9N 9R4

Tel 250 336 8767 cell 604 838 4372

chanchal@chanchalcabrera.com www.chanchalcabrera.com

Confidential Health Inventory

Today's Date _____

NOTE

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so. Please complete the questionnaire as thoroughly as possible. Thank you.

Name: _____ Age _____ Birth date _____
LAST FIRST

Address: _____ City _____ Province _____ Zip _____

Mailing Address (if different): _____

Home Phone: _____ Work Phone: _____

Fax: _____ call before faxing E-mail: _____

Employment Status: Full-time Part-time School Retired Unemployed Other

Occupation: _____

Support activities/pursuits/groups: _____

Relationship Status Single Married Divorced Widowed

Living Situation: Alone Friend(s) Partner Spouse Parents

Pets: _____

Names and ages of those living with you: _____

Name of Partner/Spouse/Parent: _____ Occupation: _____

What are the major health concerns that have brought you to this office today?

When did this condition begin?

Has anything recently changed or become worse?

Medication Name What it's for For how long? Strength Dose Frequency

ALLERGIES

Drug allergies (penicillin, etc.): _____

Allergies to foods, pollens, etc.: _____

HOSPITALIZATIONS/SURGERY

Date Hospital Diagnosis/Operation Doctor

ACCIDENTS / INJURIES Briefly describe

MORE than 5 years ago _____

LESS than 5 years ago _____

CANCER INFORMATION

Have you ever been diagnosed with cancer, a mass or tumor? Yes No

When? _____ Location _____

Type? _____ Current Status _____ Stage _____

Type? _____ Current Status _____ Stage _____

Current tumor markers _____

Date Chemotherapy/Radiation/Other Dose Frequency Duration

If you are in a clinical trial or experimental protocol please provide details. _____

PLEASE RATE THE FOLLOWING ON A SCALE OF 1 TO 10: (10 BEING THE BEST) – & WRITE IN ANY COMMENTS

Sleep _____

Energy Level _____

Appetite _____

Digestion _____

DIET AND LIFESTYLE

Dietary preferences/restrictions: _____

What is your favorite food? _____ Favorite flavor? _____

Sample of day's menu (Please also fill out 3-day food chart if you have been asked to do so)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids _____

Tobacco use (how much): _____ Previously? _____ How much? _____ How long? _____

Alcohol use (how much): _____ How often? _____

Caffeine use (how much): _____ Other mood altering substances (past/present)

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life?

FAMILY HISTORY

Please include any of the following: Alcoholism, high blood pressure, cancer, diabetes, heart disease, osteoporosis, other addiction or illness.

Member	Living?	Age	Important Diseases	Cause of death	Age
Mom	_____	_____	_____	_____	_____
Dad	_____	_____	_____	_____	_____
Sib(s)	_____	_____	_____	_____	_____
*MGM	_____	_____	_____	_____	_____
*MGF	_____	_____	_____	_____	_____
*PGM	_____	_____	_____	_____	_____
*PGF	_____	_____	_____	_____	_____
Mom's Sib(s)	_____	_____	_____	_____	_____
Dad's Sib(s)	_____	_____	_____	_____	_____

* M = Maternal P = Paternal GM = Grandmother GF = Grandfather

PERSONAL

How do you feel about the following areas of your life? Please check appropriate boxes & make any comments you would like to

	GREAT	GOOD	FAIR	POOR	COMMENTS
Self					
Work					
Spouse or significant other					
Sex					
Family					
Diet					

FOR WOMEN ONLY!

MENSTRUAL PERIODS

Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment.

Since age _____ Length of cycle _____ Flow lasts how many days? _____
Light _____ Heavy _____ Clots? _____ Color of blood _____
Menstrual cramps? _____ Which Days? _____

DATE OF LAST MENSES _____ PMS? _____
Describe symptoms: _____

HISTORY

MARK THE FOLLOWING: 1 IF CURRENT, 2 IF PAST

- | | | |
|-----------------------|-------------------------|----------------------------|
| - hysterectomy | - D&C | - dryness with intercourse |
| - irregular PAP smear | - interstitial cystitis | - breast cancer |
| - tubal ligation | - irregular bleeding | - mastectomy |
| - fibroids | - pain with intercourse | - lumpectomy |
| - herpes | - infertility | - yeast infections |
| - ablation | - | |

VAGINAL DISCHARGE? _____ Color _____ Frequency _____
Amount _____

DO YOU HAVE BREAST IMPLANTS? ___ Yes ___ No
If yes, any problems noted with these?

PREGNANCY/BIRTH CONTROL

Are you pregnant now? _____ Do you think you may be? _____
number of pregnancies _____ Number of children _____
Terminations? _____ Miscarriages? _____
Tubular pregnancies? _____ Difficulty in conceiving? _____

Birth control method(s)

MENOPAUSE

No menses since _____
Experiences/symptoms you are currently feeling/having? _____

Experiences/symptoms you had in the past during menopause? _____

HEALTH CONCERNS

Please check if you have experienced any of these **in the last 3 months**.

Skin & Hair

- | | | |
|----------------------|----------------|---------------------|
| - Rashes | - Eczema | - Recent moles |
| - Poor healing sores | - Pimples | - Change in texture |
| - Hives | - Dandruff | |
| - Itching | - Loss of hair | |

Any other problems with skin, nails or hair?

Head, Eyes, Ears, Nose and Throat

- | | | |
|--------------------------|-------------------|--------------------|
| - Cataracts | - Blurred vision | - Nose bleeds |
| - Glaucoma | - Ringing in ears | - Clicking jaw |
| - Eye pain | - Ear infections | - Facial pain |
| - Spots in front of eyes | - Sore throats | - Sinus congestion |
| - Earaches | - Canker sores | - Mucous in throat |
| - Poor hearing | - Cold sores | - Swollen glands |
| - Blurred vision | - Grinding teeth | - Frequent colds |

Any other problems with the head?

Heart and circulation

- | | | |
|------------------------|----------------------|------------------------|
| - High blood pressure | - Cold hands or feet | - Varicose veins |
| - Low blood pressure | - Phlebitis | - Difficulty breathing |
| - Chest pain | - Easy bruising | - Swelling of hands |
| - Irregular heart beat | - Blood clots | - Swelling of feet |
| - Fainting | - Palpitations | |

Any other problems with heart or circulation?

Breathing

- Cough
- Bronchitis
- Asthma
- Coughing blood
- Pneumonia
- Pain on breathing
- Shortness of breath without exertion

Difficulty breathing when lying down? _____

Production of phlegm? _____ If yes, what colour? _____

Any other problems with breathing? _____

Digestion

- Food cravings
- Poor appetite
- Bad breath
- Difficulty swallowing
- Nausea
- Vomiting
- Abdominal pain
- Indigestion
- Heartburn
- Gas
- Bloating
- Blood in stools
- Mucous in stools
- Rectal pain
- Haemorrhoids
- Diarrhoea
- Constipation
- Black stools

Number of bowel movements per day _____

___ Loose ___ Normal ___ Hard

Any other problems with digestion? _____

STOOLS

___ float ___ sink ___ daily ___ bad odor ___ no odor ___ blood in stool

Do you rely on any of the following for bowel elimination?

enemas laxatives purgatives What type/brand? _____

How often? _____

Any other problems with digestion? _____

Urinary

- Pain on urination
- Frequent urination
- Blood in urine
- Urgency of urination
- Kidney stones
- Irregular flow
- Impotency
- Inability to hold urine
- Decrease in urine flow
- Difficulty starting or stopping the flow of urine

Any other problems with urination? _____

Musculoskeletal

- Neck pain
- Muscle pain
- Stiffness
- Back pain
- Muscle weakness
- Reduced range of movement

Chiropractic or Massage therapy _____ Frequency _____
Any other musculoskeletal problems _____

General

- Fatigue
- Fevers
- Chills
- Night sweats
- Excessive thirst
- Sudden energy drops
- Slow metabolism (easy weight gain)
- Intolerance to heat or cold

Any other health concerns? _____

Neuropsychological

- Poor sleep
- Poor memory
- Numbness
- Depression
- Irritability
- Anxiety
- Seizures
- High stress levels
- Migraine
- Headaches
- Difficulty concentrating
- Foggy or spacy feeling
- Lack of coordination
- Loss of balance

Hours of sleep per 24 hours _____ Naps? _____

Stress management techniques? _____

Any other neurological or mental health problems? _____

How did you hear about Chanchal Cabrera?

CANCELLATION AGREEMENT AND WAIVER OF LIABILITY:

CONSULTANT HERBALIST: CHANCHAL CABRERA MSc, MNIMH, AHG

I, the undersigned, hereby confirm that I understand that the above named individual is not a medical doctor nor is she licensed to practice medicine. I affirm that I am consulting with this practitioner for educational purposes, of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the practitioner will offer an assessment of my general state of health and will make dietary and herbal recommendations.

I agree to the cancellation policy of this clinic:

Full fee will be charged for missed appointments and for appointments cancelled with less than **two (2) working days** notice.

Signature _____

Date _____

CLINICAL RESEARCH

For the purposes of research and continuing education, it is occasionally helpful for practitioners to review case files and to discuss cases with colleagues, or to publish specific information in professional journals where there are important lessons to be learned from a case. I would like to ask your permission to potentially use selected information from this file for such purposes. At all times identifying features will be kept private and no confidential information will be divulged. This is strictly for the purposes of learning and teaching.

Please indicate below if you give permission for such research use:

I give my permission for selected information in this file to be used for continuing learning purposes.

I do not give my permission for selected information in this file to be used for continuing learning purposes.