Cabrera Consultants

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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 / Common law □ 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?
_____
_____
_____

PERSONAL HEALTH HABITS

Height _____ Current Weight _____ Weight 1 year ago _____

Are you a smoker? _____ How many years? _____ Amount per day _____

Do you drink alcohol? _____ What? _____ Frequency? _____

Do you use recreational drugs? _____ What? _____ Frequency? _____

Do you drink coffee? _____ How much? _____ Tea? _____ How much? _____

Do you take regular exercise? _____ Frequency? _____

Type ? _____
_____
_____

Duration?
_____
_____
_____

CURRENT/RECENT HEALTH CARE PROVIDERS

Name Dates Care Provided

_____
_____
_____
_____
_____

SUPPLEMENTS & MEDICATIONS Please write a complete list on separate page if necessary.

Supplement/Herb name	Brand Name	Potency(mg, IU etc)	Dose	Frequency

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_____
_____
_____

DIETAND 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					

PLEASE RATE YOUR STRESS ON A SCALE OF O TO 10: (10 BEING THE MOST) – & WRITE IN ANY COMMENTS

Stress Level

_____

PERSONAL STRESS

1. I worry a great deal	□□Yes	□□No
2. I feel lonely	□□Yes	□□No
3. I am bored with my life	□□Yes	□□No
4. I think a lot about dying	□□Yes	□□No
5. I have particular concerns relating to my religion	□□Yes	□□No
6. I feel fearful or afraid	□□Yes	□□No
7. I feel nervous most of the time	□□Yes	□□No
8. I often feel depressed	□□Yes	□□No
9. I feel anxious often	□□Yes	□□No
10. I am ill frequently	□□Yes	□□No
11. I sometimes feel weak or light-headed	□□Yes	□□No
12. I often have pains in my shoulders, neck or back	□□Yes	□□No
13. I often feel like crying	□□Yes	□□No
14. I lose my temper more than I used to	□□Yes	□□No
Other personal concerns	□□Yes	□□No

Please describe _____

_____

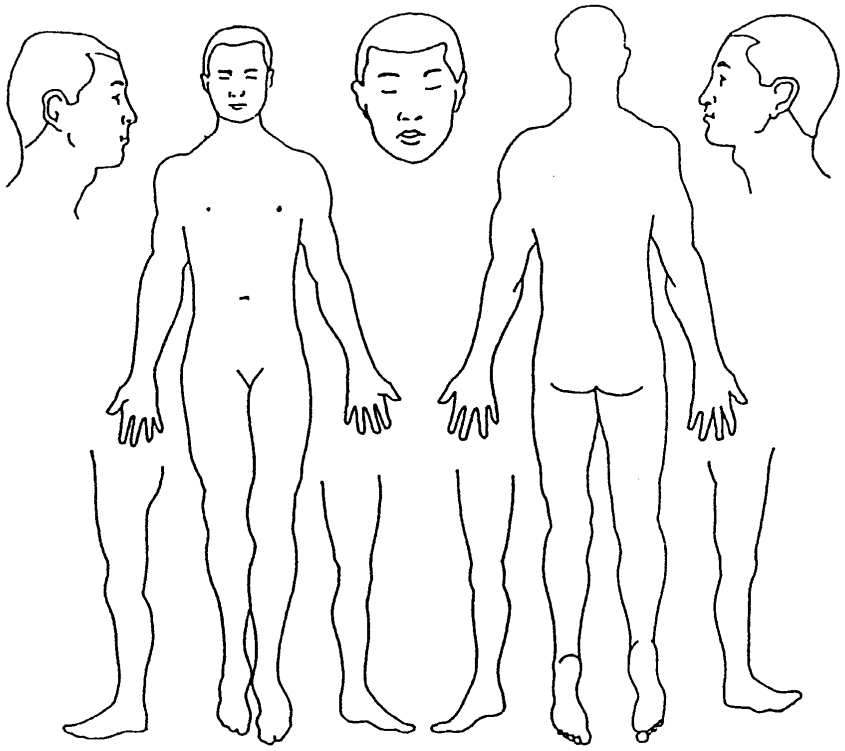
Please use this space to add any other information about yourself that you think will be of help to us:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAIN

DO YOU HAVE ANY PAIN(S)? ☐Yes ☐No

Please indicate painful or distressed areas



AREA/DESCRIPTION OF SYMPTOMS (10 BEING THE HIGHEST)	PAIN LEVEL: 0 TO 10	FREQUENVCY

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

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? _____
_____

FOR MEN ONLY

Check all that apply:

[ ] Pain or swelling of the testicles [ ] Frequent need to urinate at night
[ ] Difficulty with orgasm [ ] Premature ejaculation
[ ] Pain/Subtly of testicles [ ] Impotence/erectile dysfunction
[ ] Feeling of coldness or numbness in genitalia
[ ] Other bothersome urinary symptoms
_____

Do you get up at night to urinate? [ ] Yes [ ] No --- if Yes, How often?

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

_____
Rarely Occasionally Weekly Daily Constantly

Have you sought Medical intervention for these problems? [ ] Yes [ ] No --- if Yes, when?

What treatments have you tried for these problems and how successful have they been?

GENERAL HEALTH CONCERNS

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

Head, Eyes, Ears, Nose and Throat

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

Any other problems with the head?

_____
_____
_____

Skin & Hair

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

Any other problems with skin, nails or hair?

_____
_____
_____

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? _____
_____
_____

Heart and circulation

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

Any other problems with heart or circulation?

_____

_____

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

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

General

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

Any other health concerns? _____
_____
_____

Neuropsychological

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

Hours of sleep per 24 hours_____ Naps? _____
Stress management techniques? _____
_____
_____

Any other neurological or mental health problems?
_____
_____

CANCELLATION AGREEMENT AND WAIVER OF LIABILITY:

CONSULTANT HERBALIST: CHANCHAL CABRERA MSc, FNIMH, 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 form 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.

How did you hear about Chanchal Cabrera and the herbal medicine clinic?

_____
_____