PLEASE USE BLUE OR BLACK INK ONLY

OZARK HERBALIST, LLC

1475 W. South Street ∞ Ozark, Mo 65721 ∞ (417)581-HERB (4372)

PERSONAL INFORMATION

Name_____Date_____

Address_____E-mail_____

City_____ State_____ Zip_____

Phone_____ Cell _____ Date Of Birth_____ Age_____

Height_____ Weight (Now)_____ Weight (1 Year Ago)_____Weight (5 Years Ago)_____

Occupation_____Employer_____

Name Of Spouse_____ Spouse's Occupation_____

Referred By_____ Do you have pets/animals? _____

PURPOSE OF THIS APPOINTMENT:

How long have you had this?_____ What time(s) are the symptoms the worst?_____ The least?_____

What Aggravate(s) Your Condition: Hot?___Cold?___Dampness?__Dryness?___Motion?___Staying still?___Weather?___Stress?_____

What Activities Lessen Your Condition?_____

Other Doctors Seen For This Condition_____

When?_____

Type Of Treatment_____Results_____

Health Habits

- ❑ **Alcohol**: Type_____ Amount_____ Frequency_____
- ❑ **Tobacco/E-cig**: Quantity _____ How long_____ Interested in stopping?_____
- ❑ **Water** consumption ____glasses/day
- ❑ **Caffeine**: Coffee/tea, Cups/daily_____
- ❑ **Carbonated drinks**: ____cans/day Favorite drink_____

Nutrition & Diet Habits:

Diet**: Salt** intake_____
Fat intake_____
Sugar intake_____

- ❑ Mixed food diet (animal & plant)
- ❑ Vegan
- ❑ Vegetarian
- ❑ Lactose intolerant
- ❑ Gluten intolerant
- ❑ Egg/Albumen allergy
- ❑ Corn/Soy intolerance
- ❑ Other dietary_____

Eating Habits:

- ❑ Skip meals
- ❑ No breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Three meals/day
- ❑ Eat for comfort
- ❑ I like to snack

Favorite snack _____

Sleep:

- ❑ Difficulty falling asleep
- ❑ Continuity disturbances
- ❑ Early morning awakenings
- ❑ Daytime drowsiness
- ❑ Do you use CPAP, BPAP?

Exercise

- ❑ Regularly ____x/wk
- ❑ Over 30 min per session
- ❑ Walk, run, aerobics
- ❑ Weight training
- ❑ Other_____

Do you use artificial sweeteners? If so, which ones:

- ❑ Aspartame (NutraSweet, Equal)
- ❑ Saccharin (Sweet N Low, Sugar Twin)
- ❑ Acesulfame (Sunett, Sweet One)

Do you use any sugar substitutes?

Agave_____Honey___Truvia____Splenda_____
Monkfruit_____Sugar Alcohols _____

PRESCRIPTION MEDICATIONS: (include those taken in the last month)

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HERBS, VITAMINS, MINERALS, FOOD AND DIETARY SUPPLEMENTS:

DRUG or FOOD ALLERGIES _____

MEDICAL HISTORY

- ❑ Ringing In Your Ears
- ❑ Adult Ear Infections
- ❑ Dizziness/Fainting
- ❑ Failing Vision
- ❑ Adult Eye Infections
- ❑ Nose Bleeds
- ❑ Sinus Infections
- ❑ Sore Throats
- ❑ Hay Fever
- ❑ Allergies
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Chronic Cough
- ❑ Asthma
- ❑ Wheezing
- ❑ Chest Pain
- ❑ High Blood Pressure
- ❑ Heart Murmur
- ❑ Swollen Ankles
- ❑ Varicose Veins
- ❑ Phlebitis
- ❑ High Cholesterol / Triglycerides
- ❑ Loss of Appetite
- ❑ Persistent Hunger
- ❑ Difficult Swallowing
- ❑ Indigestion/Heartburn
- ❑ Nausea/Vomiting
- ❑ Ulcers
- ❑ Abdominal Pain
- ❑ Gallbladder Trouble
- ❑ Yellow Skin
- ❑ Hepatitis
- ❑ Change In Bowel Habits
  - ○ Diarrhea
  - ○ Constipation
- ❑ Colon Problems
- ❑ Bloody Or Black Stools
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Freq. Urine Infections
- ❑ Blood In Urine
- ❑ Overnight Urination
- ❑ Painful Urination
- ❑ Loss Of Bladder Control
- ❑ Decrease In Force/Flow
- ❑ Kidney Stones
- ❑ Venereal Disease
- ❑ Urethral Discharge
- ❑ Chronic Fatigue
- ❑ Weight Loss ____#
- ❑ Weight Gain ____#
- ❑ Anemia
- ❑ Bruise Easily
- ❑ Cancer
- ❑ High Blood Sugar
- ❑ Thyroid Problems
- ❑ Seizures/Convulsions
- ❑ Stroke
- ❑ Tremors
- ❑ Neurological Disease
- ❑ Hands Shaking
- ❑ Leg Pain
- ❑ Numbness
- ❑ Tingling Sensations
- ❑ Headaches
- ❑ Arthritis
- ❑ Muscle Pain
- ❑ Osteoporosis
- ❑ Back Pain
- ❑ Bone Fracture
- ❑ Joint Injury
- ❑ Gout
- ❑ Foot Pain
- ❑ Cold Numb Toes
- ❑ Rashes/Hives
- ❑ Psoriasis/Eczema
- ❑ Nervousness
- ❑ Anxiety
- ❑ Phobias
- ❑ Depression
- ❑ Moodiness
- ❑ Memory Loss
- ❑ Mental Illness
- ❑ Prostate Problems
- ❑ Sexual Dysfunction
- ❑ PCOS
- ❑ Frequent Infections
- ❑ Infertility
- ❑ Significant Childhood Diseases

Females Only

- ❑ Pregnant
- ❑ Planning Pregnancy
- ❑ Menstrual Flow
  - ○ Regular
  - ○ Irregular
  - ○ Painful
  - ○ Heavy
- ❑ Days Of Flow_____
- ❑ Length Of Cycle____
- ❑ 1st Day Of Last Period _____
- ❑ Pain/Bleeding During Or After Sex
- ❑ PMS
- ❑ Pelvic Inflammatory Disease

Number Of:
Pregnancies ___Abortions___
Miscarriages___Live Births___

- ❑ Birth Control Method _____
- ❑ Menopause
- ❑ Hot Flashes
- ❑ Cold Sweats
- ❑ Irritability
- ❑ Abnormal PAP
- ❑ Abnormal Breast Exam
- ❑ Surgical Menopause
- ❑ Endometriosis
- ❑ Vaginal Infections

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SURGERIES/HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

Please Give The Following Information About Your Immediate Family:

Relationship	Age If Living	Age At Death	State Of Health Or Cause Of Death
Father			
Mother			
Brothers And Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse			
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Have Any Blood Relatives Had The Following Illnesses? If So, Please Indicate Relationship:

Illness	Family Member
Diabetes	
Cancer	
Blood Disease	_____
Glaucoma	_____
Epilepsy	_____
Rheumatoid	
Arthritis	
Tuberculosis	_____
Gout	_____
High Blood Pressure	_____
Heart Disease	
Back Problems	

SIGNIFICANT LIFE EVENTS:

Please list appropriate dates and describe the nature of any traumatic experiences you have had in the past 7 years. (Divorce, injury, loss of job, change of residence, death of a loved one, etc.)

Please use this space to add any other information about yourself that you think would be helpful:

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the visit. I also agree to the $40 returned check charge in the event that my check is returned. In the case of credit card payment, arbitration of the balance due will be negotiated at the time of charge. Accounts payable in excess of 60 days will be surrendered to collections. Any outstanding balance must have proportional payments monthly. By signing this agreement, I hereby consent to financial liability for missed scheduled appointments. Should I not provide adequate notice of cancellation or fail to appear for my scheduled initial appointment, my credit card will be charged 50% of the cost of my appointment. If I fail to appear for a scheduled follow-up appointment without providing prior notice of cancellation, I understand I will be charged a fee of $50 for a missed follow up appointment..

CONSENT, DISCLOSURE, AND DISCLAIMER

I request that **Ozark Herbalist, LLC.** perform a Health Evaluation and/or BioCommunication assessment and recommend a program for the purpose of improving my health and well-being. I understand that this assessment and/or therapies are not intended as diagnosis, prescription, treatment or cures for any specific disease, physical or mental. It is not intended as a substitute for regular medical care.

NINTH AMENDMENT DECLARATION

Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care. This includes the right to choose my diet, and to obtain, purchase and use any therapy recommended by the therapist, doctor, or any practitioner of my choice.

CONSTRUCTIVE NOTICE

Notice is hereby given to any person who receives a copy of this Declaration and who, acting under the color of the law, intentionally interferes with the free exercise of the rights retained by me under the Ninth Amendment, as enumerated in this declaration, that they be in violation of my civil and constitutional rights. Title 42, U.S.C. 1983 et seq. and Title 18, Section 241

ALL INFORMATION ABIDES BY THE **FEDERAL HIPAA** (privacy and confidentiality) REGULATIONS. IF YOU WISH US TO ALLOW ANY OTHER PERSON(S) TO **ACCESS YOUR HEALTH INFORMATION or PICK UP SUPPLEMENTS**. Please list their names below:

Signature_____Date_____