The Manifest Nest
HERBAL APOTHECARY

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Wellness Assessment

The wellness assessment is used to provide insights and patterns in your overall wellbeing. As well, as provide information regarding any matters you may want to specifically address. By completing this assessment you will have a better understanding of your health and wellbeing and will be giving your herbalist an excellent starting point on which to build a healing relationship.

All information in your wellness assessment is confidential and will not be released to any person without your specific written request to do so.

General Information

Date: _____

Name: _____

Address:

_____

_____

_____

Phone: _____ Cell: _____

M: __ F: __ Age: ____ Birthdate: _____ Height: _____' _____" Weight: _____ lbs

Occupation: _____ FT _____ PT _____

Living Situation: __ Alone __ Friends __ Partner __ Spouse __ Parents __ Children __ Pets

Names and Ages of those living with you:

_____

_____

_____

What are your intentions for your visit today?

_____

_____

_____

_____

_____

_____

Please list any health care providers or consultants you are currently working with:

_____

_____

_____

_____

_____

_____

Please list all herbs, vitamins, dietary supplements you are currently taking, citing brand name whenever possible:

Product	Dosage	Frequency (number/day)

Please list all medications you are currently taking including over the counter medications (such as aspirin, antacids, etc.):

Product	OTC/P	Dosage	Frequency (number/day)

Please list all medications, herbs, supplements, etc. to which you have a known allergy:

Dietary Information

Describe below your typical meals. Please be as specific as possible by including types of oils, vegetables, proteins, and beverages, preparation types, and portion amounts.

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Water (glasses/day):

Any recurring food cravings (such as salt, starch, sugar, fat, chocolate, etc.):

Please list any known food allergies or sensitivities:

Food	Describe Reaction

Family History

Please describe any relevant or major health related issues that run in your family members (such as alcoholism, high blood pressure, cancer, diabetes, heart disease, psychiatric illness, osteoporosis, other addictions or other illnesses) Please be as specific as possible:

Mother:

Father:

Sister(s):

Brother(s):

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Other family members with pertinent issues or recurring family health trends:

Health Inventory

List all major health problems including any operations you have had:

Issue Year

_____

_____

_____

_____

_____

_____

General Health

Please check any and all that apply:

Cardio Vascular	**Skin**	**Muscles/Joints**	**Nose/Throat**
___High blood pressure	___Boils	___Backache	___Sinus congestion/ infection
___Low blood pressure	___Bruises	___Broken bones	___Nose bleeds
___Pain in heart	___Dryness	___Mobility	___Hay fever
___Poor circulation	___Itching	___Arthritis	___Sore throat
___Swelling	___Varicose veins	___Bursitis	___Tonsils
___Stroke/murmur	___Skin eruptions	___Weakness	___Canker sores
Respiratory	**Urinary/Kidney**	**Gastro-Intestinal**	**Ears**
___Chest pain	___Excessive urination	___Belching	___Ear aches
___Difficulty breathing	___Water retention	___Colitis	___Hearing loss
___Cough	___Burning urine	___Constipation	___Sinus pain/infection
___Turberculosis	___Kidney Stones	___Abdominal pain	
___Congestion	___Lower back pain	___Liver problems	**Eyes**
___Wheezing	___Dark circles under eyes	___Gallstones	___Eye pains
___Asthma	___Itchy ears/eyes	___Ulcers	___Failing vision
___Coughing up blood	___Blood in urine	___Irritable bowel	___Blepharitis

General	Male Reproductive	Female Reproductive	Contraceptives
___Fatigue	___Burning/discharge	___Age of first period	___BC pills
___Excessive thirst	___Painful testicles	___Heavy bleeding	___Diaphragm
___Difficulty sleeping	___Lumps/swelling of testicles	___Vaginal discharge	___Cervical cap
___Night sweats	___Vasectomy	___Painful intercourse	___Rhythm
___Loss of appetite	___Genital herpes	___Breast pain	___Condoms
___Warm Bodied		___Infertility	___Spermicides
___Cold Bodied		___Mood swings	___IUD
___Fever		___Regular periods	___Mucous method
___Always Hungry		___Clots	___Fertility lens
		___Cervical dysplasia	
		___Breast lump	
		___Genital herpes	
		___Dry vaginal lining	
		___Length of cycle	
		___Pains/cramps	
		___Vaginal itching	
		___Pelvic pain	
		___Anemia	
		___Anemia	
		___Hot flashes	

Please list any pregnancies you have had, including miscarriages and abortions:

Description Year

_____

_____

_____

_____

_____

_____

Emotional and Spiritual Wellbeing

Please answer the following questions as honestly and thoughtfully as possible.

Please describe your level of satisfaction with your living conditions.

Describe your ability to express your feelings and emotions.

Please describe your levels and sources of stress and in your life.

Please describe your relationship with your work.

Describe your satisfaction with your relationships.

Describe your level of loneliness.

Describe the thing in your life you would most like to change. Describe what it would take to change it.

Describe the types of things that make you nervous. Do these things dominate your thoughts?

Describe your sleep schedule and ease of sleep. How many hours in a 24 hour period do you sleep?

Describe whether or not you dream and remember your dreams.

Describe your satisfaction with your energy levels.

Describe your satisfaction and ability to wake in the morning.

Describe your hobbies and/or activities you enjoy outside of work.

List five feelings that you would describe as those that dominate your nature:

Are you at peace with your belief system? Please describe.

List approximate dates and describe any traumatic experiences you may have had in the past 7 years (such as divorce, loss of lover, job loss, move, injury, death of loved one, etc.):

Year Description of Event

Lifestyle Habits

Routine physical exercise:

Type Minutes Times per week

Tobacco use: ___Y ___N Packs per day: _____ In the past: ___Y ___N How many years: _____

Alcohol use: ___Y ___N Drinks per day: _____ Times per week: _____

Caffeine use: ___Y ___N Drinks per day: _____ Times per week: _____

Mood altering substances (such as cocaine, marijuana, etc.):

___Y ___N How much: _____ How often: _____

How many hours of television do you watch in a week? _____

Please use this space to add any other information about yourself that you think will be helpful to the success of your visit today: