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Information about your life, health history, and experience in your body helps me identify patterns and relationships in your health history. This form contains many sections which may or may not be relevant to you. Feel free to leave anything blank that is irrelevant or that you would rather not answer, or mark anything you would rather talk about in person.

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_**

**Pronouns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate and Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave a message at this number? Yes\_\_\_ No\_\_\_**

**Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle Preferred contact: phone / email**

**In case of emergency, please contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General:**

**Primary language spoken at home\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Activities, occupation, hobbies, or favorite pastimes:**

**What are you looking for support with in today’s consultation? Do you have specific health goals?**

**Any known imbalances or health issues? What diagnosis have you received? Do you agree with them?**

**Current medications, supplements, herbs, and treatments:**

**Could you possibly be pregnant?**

**Are you currently breastfeeding?**

**Please list current relationship(s) with your partner’s name, age, length of time together, and nature of relationship(s):**

**Please list children’s names, ages, and, briefly, relationship with them:**

**What is your living situation? Do you like it? Please list people and animals in your household and their relationship to you.**

**Do have a spiritual or religious practice?**

**Have you ever been exposed to toxins(lead paint, construction work, pesticides, etc.)?**

**Any hospitalizations, surgeries (including removal of tonsils or wisdom teeth), or serious injuries in the past?**

**Do you generally run warmer or colder than others around you?**

**Do you currently or have you in the past used any drugs, prescribed or otherwise?**

**Tobacco use present or past?**

**Do you drink alcohol? How many drinks per day/week/month?**

**Do you have a primary care physician? Please list and name any other care providers with whom you are working:**

**What type of exercise do you practice?**

**Please check conditions that you have experienced or are currently experienced.** (Please check with a “P” for past and a “C” for current”)

\_\_\_\_Adrenal fatigue

\_\_\_\_AD(H)D

\_\_\_\_AIDS

\_\_\_\_Alcoholism

\_\_\_\_Allergies

\_\_\_\_Anemia

\_\_\_\_Anxiety

\_\_\_\_Arthritis

\_\_\_\_Asthma

\_\_\_\_Auto-immune issues

\_\_\_\_Binge eating

\_\_\_\_Bloating

\_\_\_\_Cancer

\_\_\_\_Chemical sensitivities

\_\_\_\_Chronic pain

\_\_\_\_Constipation

\_\_\_\_Depression

\_\_\_\_Diabetes

\_\_\_\_Diarrhea

\_\_\_\_Dizziness

\_\_\_\_Early surgeries

\_\_\_\_Environmental sensitivities

\_\_\_\_Epstein-barr virus (mononucleosis)

\_\_\_\_Excess stress

\_\_\_\_Eyesight problems

\_\_\_\_Fatigue

\_\_\_\_Fibromyalgia

\_\_\_\_Headaches

\_\_\_\_Hearing problems

\_\_\_\_Heart disease

\_\_\_\_Hepatitis A

\_\_\_\_Hepatitis B

\_\_\_\_Hepatitis C

\_\_\_\_HIV

\_\_\_\_High blood pressure

\_\_\_\_Hypothyroid

\_\_\_\_Hyperthyroid

\_\_\_\_Hypoglycemia

\_\_\_\_Immune disorders

\_\_\_\_Irritable bowel Syndrome

\_\_\_\_Irritable bowel Disease

\_\_\_\_Low blood pressure

\_\_\_\_Lyme disease

\_\_\_\_Memory loss

\_\_\_\_Menopause

\_\_\_\_Menstrual irregularities

\_\_\_\_Migraines

\_\_\_\_Multiple Sclerosis

\_\_\_\_Numbness

\_\_\_\_Orthostatic hypotension

\_\_\_\_Panic Attacks

\_\_\_\_Physical, Emotional, or Sexual Abuse

\_\_\_\_Abuse before age 5

\_\_\_\_Premature birth or birth trauma

\_\_\_\_Purging Food

\_\_\_\_Painful joints

\_\_\_\_Rashes

\_\_\_\_Restricting Food

\_\_\_\_Respiratory problems

\_\_\_\_Seizures

\_\_\_\_Self Harm Behavior

\_\_\_\_Shingles

\_\_\_\_Shortness of breath

\_\_\_\_Sleep problems

\_\_\_\_Stiffness

\_\_\_\_Staph Infections

\_\_\_\_Stomach aches

\_\_\_\_Swelling

\_\_\_\_Tumors

\_\_\_\_Urinary tract infections

\_\_\_\_Yeast infections

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

**Immune System**

Use ‘**P**’ for previous condition, ‘**C**’ for current, or ‘**?**’ if unsure.

\_\_\_\_Allergies

\_\_\_\_Autoimmune disorders

\_\_\_\_Catch everything

\_\_\_\_Celiac

\_\_\_\_Chronic fatigue

\_\_\_\_Enlarged spleen

\_\_\_\_Hashimoto’s Thyroiditis

\_\_\_\_Heal slowly

\_\_\_\_Immunodeficiency

\_\_\_\_Infections

\_\_\_\_Low grade fever

\_\_\_\_Lowered resistance

\_\_\_\_Lupus (SLE)

\_\_\_\_Mononucleosis

\_\_\_\_Pernicious anemia

\_\_\_\_ Rheumatoid arthritis

\_\_\_\_Sick often

\_\_\_\_Sore throats

\_\_\_\_Swollen lymph glands

\_\_\_\_White blood cell count

Do you have any concerns about your immune system?

Are you satisfied with your energy levels?

When are the high and low points of your daily energy levels?

Have your energy levels changed markedly at any point recently or in your past? What preceded this change?

**Has anyone in your immediate family had any of the following?**

\_\_\_\_Cancer

\_\_\_\_Heart disease

\_\_\_\_High blood pressure

\_\_\_\_Low blood pressure

\_\_\_\_Diabetes

\_\_\_\_Thyroid issues

\_\_\_\_Untreated moderate to severe trauma

\_\_\_\_Autoimmune disease

\_\_\_\_Alcoholism or substance use

\_\_\_\_Suicide attempted or completed

\_\_\_\_Depression

\_\_\_\_Mental health issues

\_\_\_\_Ulcerative colitis or Crohn’s

\_\_\_\_Other

**Childhood History**

Major childhood illnesses:

Were you breastfed? How long?

Were you regularly vaccinated as a child?

Please list any recent vaccines

Please describe your birth story, if known:

Known allergies and reactions:

What has most helped? Which medicines (including herbal) have you taken for them?

Do you have allergic reactions to any drugs or herbal medicines?

**Diet**

What did you have for breakfast, lunch and dinner yesterday?

How much water did you drink yesterday?

Please fill in the below chart using the following scale:

**F** –Frequently consume (daily or more) **O**– Occasionally consume (a few times a week)

**I** – Irregularly consume (generally less than once a week)  **D** – Do not consume this

\_\_\_Alcohol

\_\_\_Black tea

\_\_\_Cigarettes

\_\_\_Coffee

\_\_\_Eat out

\_\_\_Fast food

\_\_\_Refined flour

\_\_\_Refined sugar

\_\_\_Soda

\_\_\_Soy

\_\_\_Sweets or sugar

\_\_\_Fried foods

\_\_\_Dairy

\_\_\_Fermented foods

\_\_\_Meat

\_\_\_Fish

\_\_\_Fruit

\_\_\_Nuts/seeds

\_\_\_Organic foods

\_\_\_Vegetables (raw) \_\_\_Vegetables (cooked)

\_\_\_Water

Other\_\_\_\_\_\_\_\_\_\_\_\_

What oils do you eat/cook with?

Special diets(current and/or previous):

Do you restrict your food intake?

How often do you prepare meals at home versus eating out or eating pre-prepared foods?

Do you use a microwave?

Do you crave any foods?

**Digestion**

Please use ‘**P**’ for previously, ‘**C**’ for currently or ‘**?**’ for unsure.

\_\_\_\_Anorexia nervosa

\_\_\_\_Belching

\_\_\_\_Bulimia

\_\_\_\_Crohn’s disease

\_\_\_\_Constipation

\_\_\_\_Diarrhea

\_\_\_\_Diverticulitis

\_\_\_\_Eating disorders

\_\_\_\_Flatulence

\_\_\_\_Food unappetizing

\_\_\_\_Gallstones

\_\_\_\_Giardia

\_\_\_\_Heartburn

\_\_\_\_Hemorrhoids

\_\_\_\_Digestive pain

\_\_\_\_Sudden Weight Change

\_\_\_\_Ulcer

\_\_\_\_IBS

\_\_\_\_Large appetite

\_\_\_\_Liver problems

\_\_\_\_Low appetite

\_\_\_\_Nausea

\_\_\_\_Pain after eating

\_\_\_\_Parasites

\_\_\_\_Shigella

\_\_\_\_Frequent vomiting

\_\_\_\_Ulcerative colitis

Are any symptoms worse or better after eating certain foods?

**Ears**

Use ‘P’ for past condition, ‘C’ for current, ‘I’ for intermittent or chronic and ‘?’ if unsure.

\_\_\_\_Ear infections

\_\_\_\_Earaches

\_\_\_\_Hearing loss

\_\_\_\_Overly sensitive

\_\_\_\_Tinnitus/Ringing

\_\_\_\_Wax build-up

Other\_\_\_\_\_\_\_\_\_\_\_\_

**Mouth & Throat**

Use ‘**P**’ for past condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Canker sores

\_\_\_\_Cavities

\_\_\_\_Constant dryness

\_\_\_\_Difficulty swallowing

\_\_\_\_Excess saliva

\_\_\_\_Excess mucous

\_\_\_\_Lip sores

\_\_\_\_Loose teeth

\_\_\_\_Mouth sores

\_\_\_\_Oral herpes

\_\_\_\_Painful/tight jaw

\_\_\_\_Receding gums

\_\_\_\_Sinus problems

\_\_\_\_Sore gums

\_\_\_\_Sore throats

\_\_\_\_Swollen glands

\_\_\_\_Swollen tongue

\_\_\_\_White coating on tongue

Other\_\_\_\_\_\_\_\_\_\_\_\_

**Headaches**

Do you ever have headaches? How often? How long have you had them?

Location and type of headaches:

Other symptoms associated with the headache (i.e., stomach pain):

What medicines and treatments have you tried, and which were most successful?

**Urinary Tract**

Use ‘**P**’ for past condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Bloating

\_\_\_\_Blood in urine

\_\_\_\_Burning urination

\_\_\_\_Frequent urge to urinate

\_\_\_\_Kidney/bladder stones

\_\_\_\_Kidney pain

\_\_\_\_Strong smelling urine

\_\_\_\_Urinary tract infections

\_\_\_\_Water retention

Other\_\_\_\_\_\_\_\_\_\_

Approximately how many times a day do you urinate?

Do you wake up at night to urinate? How often?

Is it ever difficult to urinate?

After urinating, does it ever feel like you still have urine in your bladder?

Have you had urinary tract infections? How often? What medicines or treatments have you tried and which were most effective?

**Bowel Movements**

How many times a day do you defecate?

Do your feces tend toward soft or hard?

Are you ever constipated? How often?

Do you ever have diarrhea (very loose stools)?

Is your need to defecate urgent?

Does it ever hurt to defecate?

After you defecate, does it ever feel like your bowel hasn’t fully evacuated?

Please circle any that apply to your stool:

brown, green, yellow, black, bloody, floating, sinking

Other bowel problems or symptoms:

**Sexual and Reproductive System Health**

Have you had any of the following? Use ‘**P**’ for past condition, ‘**C**’ for current, , and ‘**?**’ if you’re unsure

\_\_\_\_AIDS

\_\_\_\_Candida

\_\_\_\_Chlamydia

\_\_\_\_Crabs/lice

\_\_\_\_Gardnerella

\_\_\_\_Genital warts

\_\_\_\_Gonorrhea

\_\_\_\_Herpes (I or II)

\_\_\_\_HIV

\_\_\_\_Syphilis

\_\_\_\_Human Papilloma Virus(HPV)

\_\_\_\_Trichomonas

\_\_\_\_Urethritis

Please list any herbs or drugs you have used as treatment for the above.

Have you had any of the following? Use ‘**P**’ for past condition, ‘**C**’ for current, or ‘**?**’ if unsure.

\_\_\_\_Bacterial vaginosis

\_\_\_\_Benign Prostatic Hyperplasia (BPH)

\_\_\_\_Blood in semen

\_\_\_\_Blood in urine

\_\_\_\_Breast pain

\_\_\_\_Cervical dysplasia

\_\_\_\_Cysts

\_\_\_\_Difficulty getting urine flowing

\_\_\_\_Dribbling

\_\_\_\_Endometriosis

\_\_\_\_Erectile dysfunction

\_\_\_\_Fibroids

\_\_\_\_Frequent urination

\_\_\_\_Impotence

\_\_\_\_Infertility

\_\_\_\_Interrupted flow of urine

\_\_\_\_Painful ejaculation

\_\_\_\_Painful intercourse

\_\_\_\_Painful to urinate

\_\_\_\_Pelvic inflammatory disease (PID)

\_\_\_\_Penis pain

\_\_\_\_Prostate pain

\_\_\_\_Prolapsed Uterus

\_\_\_\_Testicle pain

\_\_\_\_Tumors

\_\_\_\_Unusual PAP

\_\_\_\_Vaginal discharge

\_\_\_\_Vaginal dryness

\_\_\_\_Vaginal infection

\_\_\_\_Vaginitis

Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about emotional health related to your hormonal cycles?

Are you currently taking any form of hormones?

Are you sexually active?

Do you use any safer sex practices? If so, what kind?

Have you ever been tested for sexually transmitted infections or gotten a pap smear? When?

**Pregnancies Dates:**

Number of miscarriages:

Number of abortions:

Children:

Please describe the birth(s) of your child(ren):

Do you have any concerns about your sexuality?

**Menstrual Cycle**

\_\_\_\_Acne or skin changes

\_\_\_\_Bleeding between cycles

\_\_\_\_Bloating

\_\_\_\_Painful menses (how is it painful?)

\_\_\_\_Breast pain

\_\_\_\_Ovulation Pain

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average number of days bleeding: \_\_\_\_\_

Approximately how many days are there between your menses? Are they regular or irregular?

Do you have any concerns about emotional health related to your menstrual cycles?

**Menstrual Blood**

\_\_\_\_Bright red

\_\_\_\_Clots

\_\_\_\_Dark colored

\_\_\_\_Heavy flow

\_\_\_\_Scanty flow

\_\_\_\_Slow flowing

Other\_\_\_\_\_\_\_\_\_\_

**Menopause**

Are you currently experiencing menopause?

If you are postmenopausal, at what age did you experience menopause?

\_\_\_\_Dry vaginal mucosa

\_\_\_\_Hormone replacement therapy

\_\_\_\_Hot flashes

\_\_\_\_Mood swings

\_\_\_\_Night sweats

\_\_\_\_Osteoporosis

\_\_\_\_Sore muscles

Other\_\_\_\_\_\_\_\_\_\_

**Sleep Patterns**

On a scale from **1**(rarely) to **5** (very often) mark the conditions pertinent to you.

\_\_\_\_Fall asleep fast

\_\_\_\_Sleep through the night

\_\_\_\_Hard to fall asleep, but easy to stay asleep

\_\_\_\_Hard to fall asleep or remain asleep

\_\_\_\_Wake often. What hours?

\_\_\_\_Wake up to urinate

\_\_\_\_Restless sleep

\_\_\_\_Restful sleep

\_\_\_\_Hard to wake up

\_\_\_\_Sleepless nights

What hours do you generally sleep? Is your sleep schedule regular?

Generally, how many hours of sleep do you need to feel rested?

Do you feel rested when you wake in the morning?

**Cardiovascular Health**

Use ‘**P**’ for past condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Angina

\_\_\_\_Irregular heartbeat

\_\_\_\_Arteriosclerosis

\_\_\_\_Bruise easily

\_\_\_\_Bleed easily

\_\_\_\_Capillary fragility

\_\_\_\_Cardiac arrest

\_\_\_\_Chest pains

\_\_\_\_Congenital deformities

\_\_\_\_Congestive heart failure

\_\_\_\_Edema

\_\_\_\_Fast heartbeat (tachycardia)

\_\_\_\_Heart attack

\_\_\_\_Heart flutter

\_\_\_\_Heart irregularities

\_\_\_\_Heart murmur

\_\_\_\_High blood pressure

\_\_\_\_Ischemia

\_\_\_\_Low blood pressure

\_\_\_\_Mitral valve prolapse

\_\_\_\_Palpitation

\_\_\_\_Pericarditis

\_\_\_\_Poor circulation

\_\_\_\_Rheumatic fever

\_\_\_\_Slow heart beat (bradycardia)

\_\_\_\_Stroke

\_\_\_\_Varicose veins

Other\_\_\_\_\_\_\_\_

Blood pressure (average) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cholesterol (if know, LDL, HDL and total cholesterol):

Blood type, if known:

**Emotional Health**

Please describe your emotional and mental health:

Use ‘**P**’ for previous condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure. Please also follow a scale of **1** (not a big problem) to **5** (major problem).

\_\_\_\_Anxiousness

\_\_\_\_Bipolar

\_\_\_\_Butterflies in stomach

\_\_\_\_Cannot stay asleep

\_\_\_\_Excessive stress

\_\_\_\_Diminished taste

\_\_\_\_Depression

\_\_\_\_Hard to relax

\_\_\_\_Fluctuating vision

\_\_\_\_Hard to concentrate

\_\_\_\_Hopelessness

\_\_\_\_Involuntary spasms

\_\_\_\_Mania

\_\_\_\_Memory loss

\_\_\_\_Nervousness

\_\_\_\_Numbness

\_\_\_\_Pain (constant)

\_\_\_\_Panic attacks

\_\_\_\_Dramatic seasonal emotional changes

\_\_\_\_Sudden mood swings

\_\_\_\_Trouble falling asleep

\_\_\_\_Twitching

\_\_\_\_Worsening coordination

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your stress levels. What happens with your body when stress levels are elevated?

Do you like your body?

**Respiratory**

Use ‘**P**’ for previous condition, ‘**C**’ for current, ‘**I**’ for intermittent or chronic and ‘**?**’ if unsure.

\_\_\_\_Asthma

\_\_\_\_Bronchitis

\_\_\_\_Chest pain

\_\_\_\_Common cold

\_\_\_\_Coughing

\_\_\_\_Difficulty smelling

\_\_\_\_Flu (influenza)

\_\_\_\_Fluid in lungs

\_\_\_\_Hay fever

\_\_\_\_Laryngitis

\_\_\_\_Pleuritis

\_\_\_\_Respiratory inflammation

\_\_\_\_Runny nose

\_\_\_\_Shortness of breath

\_\_\_\_Sneezing

\_\_\_\_Stuffy nose

\_\_\_\_Tight around lungs

\_\_\_\_Trouble breathing in

\_\_\_\_Trouble breathing out

\_\_\_\_ Wheezing

\_\_\_\_Whooping Cough

\_\_\_\_Tuberculosis

Other\_\_\_\_\_\_\_\_\_\_\_

Do you have much congestion? During which season is it better or worse? What helps it?

**Mucous**: quality and/or color

\_\_\_\_Clear

\_\_\_\_Green

\_\_\_\_Yellow

\_\_\_\_Thick/sticky

\_\_\_\_Thin/runny

Worse in the morning, afternoon, evening, night (circle)

Have you identified foods, environmental factors or situations that worsen your breathing?

What are they?

**Cough:** Check the symptoms which pertain to you.

\_\_\_\_Bloody

\_\_\_\_Dry cough

\_\_\_\_Hacking

\_\_\_\_Itchy throat

\_\_\_\_Painful

\_\_\_\_Persistent

\_\_\_\_Regularly

\_\_\_\_Wet cough

Worse at morning, afternoon, evening, night (circle)

Triggers:

**Is there anything else you wish to share?**