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Information about your life, health history, and experience in your body helps me identify relevant patterns in order to better support you. I see people for many reasons, and 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.

All information is confidential.

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

**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, health issues, or diagnosis? Do you agree with your diagnosis?**

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

**Known allergies and reactions, including medications and herbal medicines:**

**Could you possibly be pregnant?**

**Are you currently breastfeeding/chestfeeding?**

**Please list current relationship(s), 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?**

**What resources do you have in your life? Include supportive relationships, spiritual resources, healing work you receive, support groups, self-care practices, hobbies or meaningful work.**

**Please list any suicide attempts or the nature of any violent behavior:**

**When do you feel the most joy and fulfillment in your life?**

**What do you consider your greatest personal strengths?**

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

**Tobacco use present and past:**

**Alcoholic drinks per day/week/month:**

**Significant drug use past or present:**

**Please list and name any other care providers with whom you are working, including primary care, counseling, etc:**

**What are your current (and previous, if relevant) levels of physical movement?**

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

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

\_\_\_\_AIDS

\_\_\_\_Alcoholism

\_\_\_\_Allergies

\_\_\_\_Anemia

\_\_\_\_Anxiety

\_\_\_\_Arthritis

\_\_\_\_Asthma

\_\_\_\_Autism

\_\_\_\_Autoimmune issues

\_\_\_\_Binge eating

\_\_\_\_Cancer

\_\_\_\_Chemical sensitivities

\_\_\_\_Chronic pain

\_\_\_\_Constipation

\_\_\_\_Depression

\_\_\_\_Diabetes

\_\_\_\_Diarrhea

\_\_\_\_Dizziness

\_\_\_\_Environmental sensitivities

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

\_\_\_\_Excess stress

\_\_\_\_Eyesight problems

\_\_\_\_Fatigue

\_\_\_\_Fibromyalgia

\_\_\_\_Headaches

\_\_\_\_Hearing problems

\_\_\_\_Heart disease

\_\_\_\_Hepatitis

\_\_\_\_HIV

\_\_\_\_High blood pressure

\_\_\_\_Hypothyroid

\_\_\_\_Hyperthyroid

\_\_\_\_Hypoglycemia

\_\_\_\_Irritable Bowel Syndrome (IBS)

\_\_\_\_Inflammatory bowel Disease (IBD)

\_\_\_\_Low blood pressure

\_\_\_\_Lyme disease

\_\_\_\_Memory loss

\_\_\_\_Menstrual irregularities

\_\_\_\_Migraines

\_\_\_\_Multiple Sclerosis

\_\_\_\_Numbness

\_\_\_\_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

\_\_\_\_Shingles

\_\_\_\_Sleep problems

\_\_\_\_Stiffness

\_\_\_\_Staph Infections

\_\_\_\_Stomach aches

\_\_\_\_Tumors

\_\_\_\_Urinary tract infections

\_\_\_\_Yeast infections

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

**Nervous system**

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

\_\_\_\_Anxiousness

\_\_\_\_Bipolar

\_\_\_\_Butterflies in stomach

\_\_\_\_Excessive stress

\_\_\_\_Diminished taste

\_\_\_\_Depression

\_\_\_\_Hard to relax

\_\_\_\_Hard to concentrate

\_\_\_\_Headaches

\_\_\_\_Hopelessness

\_\_\_\_Involuntary spasms

\_\_\_\_Mania

\_\_\_\_Memory loss

\_\_\_\_Nervousness

\_\_\_\_Numbness

\_\_\_\_Parkinson’s

\_\_\_\_Pain

\_\_\_\_Panic attacks

\_\_\_\_Dramatic seasonal emotional changes

\_\_\_\_Sudden mood swings

\_\_\_\_Seizures

\_\_\_\_Sleep issues

\_\_\_\_Twitching

\_\_\_\_Worsening coordination

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

**Please describe your emotional and mental health:**

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

Describe any consistent pain, using a scale of 1-10.

Do you ever have headaches? How often? How long have you had them? Where is the pain?

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

**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?

**Nutrition**

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?

Are you sensitive, intolerant, or allergic to any foods?

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 disorder

\_\_\_\_Flatulence

\_\_\_\_Food unappetizing

\_\_\_\_Gallstones

\_\_\_\_Giardia

\_\_\_\_Heartburn

\_\_\_\_Hemorrhoids

\_\_\_\_Digestive pain

\_\_\_\_Sudden Weight Change

\_\_\_\_Ulcer

\_\_\_\_Irritable bowel syndrome

\_\_\_\_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?

**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 or Mental health concerns

\_\_\_\_Ulcerative colitis or Crohn’s

**Childhood History**

Major childhood illnesses:

Were you breastfed/chestfed? How long?

Please describe your birth, if known:

**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

\_\_\_\_Swollen lymph glands

\_\_\_\_White blood cell count

Do you have any concerns about your immune system?

What are your energy levels like?

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?

**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

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\_\_\_\_\_\_\_\_\_\_\_\_

**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

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?

**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

**Sexual and Reproductive System Health**

\_\_\_\_Chlamydia

\_\_\_\_Crabs/lice

\_\_\_\_Gardnerella

\_\_\_\_Genital warts

\_\_\_\_Gonorrhea

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

\_\_\_\_HIV

\_\_\_\_Syphilis

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

\_\_\_\_Trichomonas

\_\_\_\_Urethritis

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

\_\_\_\_AIDS

\_\_\_\_Bacterial vaginosis

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

\_\_\_\_Blood in semen

\_\_\_\_Blood in urine

\_\_\_\_Breast pain

\_\_\_\_Chlamydia

\_\_\_\_Cervical dysplasia

\_\_\_\_Cysts

\_\_\_\_Difficulty getting urine flowing

\_\_\_\_Dribbling

\_\_\_\_Endometriosis

\_\_\_\_Erectile dysfunction

\_\_\_\_Fibroids

\_\_\_\_Frequent urination

\_\_\_\_Gonorrhea

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

\_\_\_\_HIV

\_\_\_\_Human Papilloma virus (HPV)

\_\_\_\_Infertility

\_\_\_\_Interrupted flow of urine

\_\_\_\_Painful ejaculation

\_\_\_\_Painful intercourse

\_\_\_\_Painful to urinate

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

\_\_\_\_Penis pain

\_\_\_\_Prostate pain

\_\_\_\_Prolapsed Uterus

\_\_\_\_Syphilis

\_\_\_\_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?

**Pregnancies Dates:**

Miscarriages:

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

\_\_\_\_Breast pain

\_\_\_\_Ovulation Pain

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

**Menopause**

\_\_\_\_Dry vaginal mucosa

\_\_\_\_Hormone replacement therapy

\_\_\_\_Hot flashes

\_\_\_\_Mood swings

\_\_\_\_Night sweats

\_\_\_\_Osteoporosis

\_\_\_\_Sore muscles

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

Are you currently experiencing menopause?

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

**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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood type, if known:

**Respiratory**

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

\_\_\_\_Asthma

\_\_\_\_Bronchitis

\_\_\_\_Chest pain

\_\_\_\_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)

**For Somatic Experiencing Clients:**

**What are your goals for therapy?**

 **Have you done any kind of therapy or somatic practice before? If so, please list length of time, with whom, and reason for ending:**

**Please indicate events that you experienced before the age of 18:**

\_\_\_ Involvement with the foster care system?

\_\_\_ Homelessness?

\_\_\_ Was there emotional abuse from a parent/adult in the home?

\_\_\_Physical abuse? (Pushing, grabbing, slapping, throwing something at you, or injuring you.)

\_\_\_ Did a person at least 5 years older than you ever touch you in a sexual way or have you touch their body in a sexual way, or have or attempt to have any kind of sex with you?

\_\_\_ Did you often feel that no one in your family loved you or thought you were special and important? Did you feel distant from your family and not cared about or supported?

\_\_\_ Did you often feel as though you didn’t have anyone to protect you, didn’t receive adequate medical care, have enough to eat, or had to wear dirty clothes due to parental neglect? Were your parents too drunk or high to take care of you?

\_\_\_Were your primary caregivers ever separated, divorced, or estranged?

\_\_\_Did you witness a parent in your household be physically harmed or threatened with violence?

\_\_\_ Did you live with anyone who used drugs or whose alcohol use was a problem?

\_\_\_Was there depression, mental illness, or attempted suicide by a family member?

\_\_\_Incarceration of a family member?

\_\_\_separation from caregivers?

**On a separate sheet of paper, please describe your early life. What caregivers did you grow up with? What were their strengths and challenges? How did they treat each other? How did they treat you? Did you feel bonded with them as a child? What major changes occurred?**

**Please also describe your current family, dynamics, parenting style, and strengths and challenges of primary relationship(s).**