Ashland Gold Hill Dispensary
Dispensary 315 2nd Ave
1526 Siskiyou Blvd Gold Hill Or 97525
Ashland Or 97520 (541)8558797
(541) 7086446

Health History Questionnaire

Please Note. This detailed intake form has many questions that may or may not pertain to your condition. These questions are searching for potentially undiagnosed conditions and connections between ailments. Please feel free to answer only those questions you feel are important towards your health concerns, or take the time to finish the full form. Any questions that you would rather discuss in person can be marked off for future discussion.

Name _____ Today's date _____
Address _____
Phone: Home _____ Cell _____
Email_____ Date of birth _____ Age _____
Male/Female/Non-Binary/Other (Circle one) Height _____ Current Weight _____
Highest Adult Weight _____ Lowest Adult Weight _____
Relationship status_____ Children_____
Occupation _____

Main Reasons for visit (diagnoses, main complaints and symptoms)
1._____ 2._____ 3._____
Other health concerns:

Hobbies, skills, interests, favorite pastimes

Movement Routine what type of daily, weekly or monthly exercises do you practice
Type: Frequency:

Practitioners Are you currently under the care of a healthcare practitioner? Please note which of the following types of health care practitioners you have seen. Use '**P**' if you have seen them in the past and '**C**' if you are currently under their care.

____Ayurvedic practitioner
____Naturopath
____Psychiatrist
____Social Worker
____Psychologist
____Massage
____Herbalist
____Spiritual therapist
____Traditional counselor

____Bodywork
____Chinese Medicine
____Chiropractor (type)_____
____Homeopath
____Occupational Medical doctor
____Physical therapist therapist (type)_____
Other_____

Western medical diagnosis known (please include any significant lab reports) and who made these diagnoses?

Current medications and treatments (please include all dietary supplements):

Previous medications and treatments:

Health History Please check any of the below symptoms or diseases you have experienced. Use a scale of **1-5**, **1** the least and **5** being the most severe. If unsure, use a question mark '**?**'.

____AD(H)D
____AIDS
____Alcoholism
____Allergies
____Anemia
____Anxiety
____Arthritis
____Asthma
____Bloating
____Cancer
____Chemical sensitivities
____Chronic fatigue
____Common cold
____Constipation
____Diabetes
____Diarrhea
____Dizziness
____Drug abuse
____Epilepsy
____EpsteinBarr virus
____Excess stress
____Eyesight problems
____Environmental sensitivities
____Hepatitis B
____Hepatitis C
____High blood
____Hepatitis C
____High blood Pressure
____HIV
____Hyperglycemia
____Hypoglycemia
____Immune disorders
____Injuries
____Low blood Pressure
____Male health Problems
____Memory lose
____Menopause problems
____Menstrual problems
____Menstrual irregularities
____Numbness
____Painful joints
____Rashes
____Respiratory problems
____Seizures

____Shingles
____Shortness of breath
____Seizures
____Shingles
____Shortness of
____Stomach aches
____Swelling
____Tumors
____Urinary tract
____ Sleep problems
____Sore throats
____Stiffness
____Stomach aches
____Swelling
____Tumors
____Urinary tract infections
Other_____

Immune System Please mark '**P**' for previous condition, '**C**' for current and '**?**' if unsure.

____Adenitis
____Allergies
____Autoimmune disorders
____Catch everything
____Chronic fatigue
____Enlarged spleen
____Graves disease
____Hashimoto's thyroiditis
___Heal slowly
____Infections
____Immunodeficiency
____Low grade fever
____Lowered resistance
____Lupus (SLE)
____Myasthenia gravis
____ Mononucleosis
____Pernicious
____Anemia
____Rheumatoid arthritis
____Lowered resistance
____Lupus (SLE)
____Myasthenia gravis
____Mononucleosis
____Pernicious anemia
____Rheumatoid arthritis
____Sick often
____Sore throats
____Swollen
____Sick often
____Swollen lymph glands
____White blood Cell count Other_____

Do you have any concerns about your immune system?

Childhood diseases and syndromes

____Allergies
____Chicken pox
____Mononucleosis
____Whooping cough
____Asthma
____German measles
____Mumps (Pertussis)
____Atopic eczema (Rubella)
____Rheumatic fever
____Bronchitis
____Measles
____Tonsillitis
Other_____

Skin Mark any of the conditions below that pertain to you. Use '**P**' for past problem and '**C**' for current.

____Acne
____Boils
____Bruise easily
____Dry hair
____Dry skin
____Eczema/psoriasis
____Hair loss
____Impetigo
____Itchy
____Moles
____Oily hair
____Oily skin
____Pimples
____Rashes
____Scars
____Sensitive to chemicals
____Skin tags
____Scars
____Slow to heal
____Varicose veins

Other_____

Energy Levels:

Are you satisfied with your energy levels, please describe .

When is the high point and low point of your daily energy levels?

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

Hospitalization Name any circumstances in which you were hospitalized and why (list approximate date and duration of stay)

What was your treatment, were there any follow ups?

Which immunizations and vaccines have you received?

Please list any surgeries you've had along with approximate dates and reasons for them

Injuries What serious injuries have you had?

What therapies and/or drugs did you take for them?

Have you ever been in an automobile or other serious accidents?

Have you ever injured your spine or back?

Family History

Has anyone in your immediate family had any of the following:

____Cancer
____High blood pressure ____Diabetes
____Heart disease
____Low blood pressure Other_____

Drug History Please list any previous medical or recreational drugs you have used in your past

Allergies Do you have any allergies, what are they?

Which medicines (including herbal) have you taken for them?

When and where are your allergies least and most troublesome?

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

What has most helped your allergies?

Diet 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
____Eat out
____Juice
____Baked goods
____Eggs
____Milk
____Beef

____Fast food
____Nut butters
____Beer
____Fermented foods
____Nuts/seeds
____Black tea
____Fish
____Organic foods
____Bread
____Fried foods
____Pork
____Cheese
____Fruit
____Potato chips
____Chicken
____Grains
____Refined flour
____Cigarettes
____Green tea
____Refined sugar
____Coffee
____Herbal tea
____Seafood
____Seaweed
____Soda
____Sweets
____Tea
___Vegetables cooked
____Vegetables raw
____Water
____Wine

***Special diets**; current and/or previous

Digestion Please use '**P**' for previously, '**C**' for currently or '**?**' for unsure.

____Anorexia nervosa
____Bulimia
____Belching
____Constipation
____Changes in bowel Habits
____Crohn's disease
____Diverticulitis
____Dysentery
____Diarrhea
____Eating disorders Syndrome
____Food unappetizing
____Flatulence
____Gallstones
____Giardia
____Hemorrhoids
____Heartburn
____Irritable bowel
____Indigestion
____Liver problems
____Large appetite
____Low appetite
____Nausea
____Pain after eating
____Parasites
____Shigella
____Stomach aches
____Sudden weight
____Ulcer
____Ulcerative colitis
____Vomiting
Other_____

What are your favorite and least favorite foods?

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

Using a scale of **1** (least favorite) to **5** (favorite) mark the following tastes and spices
____Bitter
____Fatty

____Pungent
____Spicy
____Cold (temperature)
____Hot (temperature)
____Salty
____Sweet
___Dry texture
____Moist texture
____Sour
Other_____

Body Temperature Please write '**H**' for Hot and '**C**' for Cold, if applicable to these body areas
____General body
____Palms
____Feet
____Chest
____Arms
____Fingers
____Genital region
____Stomach
____Hands
____Legs
____Head
Other_____

Using a scale of **1** (least favorite/strong aversion) to **5** (favorite) check off these weather conditions
____Hot
____Cold
____Damp
____Humid
____Very hot
____Very cold
____Dry

What is your favorite temperature range?

What part of the day are you warmest and coldest?

Emotional Use a scale of **1** (rare) to **5** (very common) on the below conditions that are pertinent to you:
____Angry
____Dreamy
____Happy

____Sad
____Anxious
____Enthusiastic
____Inspired
____Think a lot
____Attentive
____Fearful
____Lethargic
____Worry
____Bipolar
____Forgetful
____Manic
____Depressed
____Grumpy
____Nervous
Other_____
Have you taken medication for emotional support, if so which? How long? Using currently?

Memory How is your long-term and short term memory?

Has your memory changed noticeably in the past few years?

Eyesight Are you near or farsighted, do you wear corrective lenses?
Does the prescription for these change often?

Ears
Have you previously had '**P**' or currently have '**C**'
____Ear infections
____Overly sensitive
____Tinnitus/Ringing
____Hearing loss
____Wax buildup
Other_____
How is your hearing, has it changed in the past years?

Mouth & Throat
Please list '**P**' for previous or '**C**' for current conditions
____Cavities
____Excess saliva
____Oral herpes
____Swollen glands

____Constant dryness
____Lip sores
____Painful/tight jaw
____Swollen tongue
____Difficultly Swallowing
____Loose teeth
____Sore gums
____Mouth sores
____Sore throats
Other_____

Headaches Do you ever have headaches, how often.
How long have you had them?
Location/type of headaches

____After eating
____Back of head
____Afternoon
____Band around
____Around eyes head
____Around temples
____Before eating
____Aversion to stimuli
____Chronic
____Cluster
___Constant
____Dull
____Evening
____Front of head
____Left side
____Migraine
____Morning
____Night
____Pounding
___Premensis
____Right side
Other_____

What triggers them?

Are they seasonal? If so, which season?

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

Are they more or less often than in the past?

Does the severity or intensity vary from episode to episode?

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

Urinary Tract Please mark '**P**' for previous and '**C**' for current for any of the below conditions
____Bloating
____Kidney/bladder stones
____Urinary tract
____Blood in urine
____Kidney pain infections
____Burning urination
____Lower back pain
____Water retention
____Frequent urge to urinate
____Strong smelling urine
Other_____

Approximately how many times a day do you urinate?
Do you wake up at night to urinate, how many times?
Is it ever difficult to urinate?
Does it ever seem urgent?
Have you had urinary tract infections?
How often do they present?
How did you treat them?
After urinating, does it ever feel like you still have urine in your bladder?

Bowel Movements
How many times a day do you defecate?
Is it ever difficult to defecate?
Do you strain to defecate?
Do your feces tend toward loose (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?
Are your stools often very strong smelling?

Other bowel problems or symptoms?

Reproductive Health

Have you had any of the following. Write '**P**' for previously '**C**' for currently, '**S**' if you suspect you may have or '**?**' if you have a question about it. ____AIDS ____Genital warts ____Syphilis ____Candida ____Gonorrhea ____STDs ____Chlamydia ____HIV ____Trichomonas ____Crabs/lice ____Human Papillomavirus ____Urethritis ____Gardnerella (HPV) Other_____

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

Do you get up at night to urinate, how often?
Does your prostate region ever hurt?
If yes, is pain dull, constant, throbbing or sharp?
Is it ever painful to urinate – describe the pain

Reproductive Health Cnt' Have you had any of the following symptoms or conditions. Use '**P**' for previously and '**C**' for currently or '**?**' if unsure.

Does the urge to urinate interfere with your daily activities?
Do you have any problems getting and/or maintaining an erection?
Do you have any health concerns about your sexuality or vitality?

Reproductive Health

Use '**P**' for past condition, '**C**' for current, '**S**' for unsure or '**?**' for any questions.

____Breast pain
____Cervical dysplasia
____Cysts
____Endometriosis
____Fibroids
____Infertility
____Miscarriage
____Painful intercourse
____Pelvic inflammatory disease (PID) ____STDs
____Tumors
____Unusual PAP
____Vaginal discharge
____Vaginal dryness
____Vaginal infection
_____Vaginitis

____Benign Prostatic Hyperplasia (BPH)
____Blood in semen
____Blood in urine
____Difficulty getting urine flowing
____Dribbling
____ Erectile dysfunction
____Sexual thoughts
____Frequent urination
____Impotence
____Interrupted flow of urine
____Libido low
____Orchitis
____Painful ejaculation
____Painful to urinate
____Penis pain
____Prostate pain
____Testicle pain

____Vitality low

Other_____

Menstrual Cycle

____Acne
____Bloating (feet, hands, ankles)
____Bleeding between cycles
____Irregular cycle
____Mood swings
____Painful mensis
____Bloating (hands, stomach)

Menstrual Discharge

____Bright red
____Heavy flow
____Red brown
____Clots
____Profuse flow
____Scanty flow
____Dark colored
____Red
____Slow flowing
Other_____
Average number of days bleeding Approximately how many days between mensis, is it regular or irregular?

Other_____

____Dry vaginal mucosa
____Hot flashes
____Hormone replacement therapy
____Mood swings
____Night sweats
____Osteoporosis
____Sore muscles

Menopause

Are you currently in pre, peri or post menopause?

Contraception Method

____Birth control pills ____Diaphragm ____IUD ____None ____ 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
____Restless sleep

____Restful sleep
____Hard to fall asleep, but stay asleep
___ Hard to fall and stay asleep
____Wake often
____Wake up to urinate
____Hard to wake up
____Wake often
____Wake up to urinate
____Hard to wake up
____Stay awake till 11:00pm
____Stay awake till 1:00am
____Stay awake till 3:00am
Other_____

Generally, how many hours of sleep do you need to feel rested?
Do you feel rested when you wake in the morning?

Dreams (circle those that apply): active, lucid, anxious, nightmares, probing, pleasant, interesting, scary, other_____
Which are your favorite hours to sleep?

Cardiovascular Health Please check the below questions pertinent to your health:
____Angina
____Chest pain

____Heart attack
____Palpitation
____Arrythmias
____Congenital (myocardial infarction)
____Pericarditis (irregular heartbeat)
____Heart flutter
____Poor circulation
____Arteriosclerosis
____Congestive heart
____Heart irregularities
____Rheumatic fever
____Black and blue failure
____Heart murmur
____Slow heart beat easily
____Edema
____High blood pressure (bradycardia)
____Bleed easily
____Fast heartbeat
____Ischemia
____Stroke
____Capillary fragility (tachycardia)
____Low blood pressure
____Varicose veins
____Cardiac arrest
____Mitral valve prolapse
Other_____

Resting pulse rate_____
Blood pressure (avg)_____ Cholesterol (if know, LDL, HDL and total cholesterol)_____

Does your family have a history of heart conditions, what are they?

What are some of your other blood pressure readings over the past 3 years?

What drugs, herbal medicines or other treatments have you used?

Nervous System and Stress Please mark with '**P**' for previously and '**C**' currently to any conditions that are pertinent to you. Please also follow a scale of **1** (noticeable but not a big problem) to **5** (major problem).
____Anxiousness
____Fluctuating vision

____Panic attacks
____Bipolar
____Hard to concentrate
____Seasonal affective
____Butterflies in stomach
____Involuntary spasms disorder
____Cannot stay asleep
____Mania
____Sudden mood swings
____Constant feeling of stress
____Memory loss
____Trouble falling asleep
____Diminished taste
____Nervousness
____Twitching
____Depression
____Numbness
____Worsening coordination
____Fear of facing a new day
____Pain – constant
Other_____

Describe your stress levels, what goes wrong with your body when stress levels are elevated.

How are your stress levels 1 (lowest) to 5 (most stressful) in each:
___ Home
___ Work
___ Health
___ Social

Respiratory

Please mark with a '**P**' for previously a problem, '**C**' for currently so, and '**?**' if unsure. ____Asthma
____Bronchitis
____Chest pain
____Common cold
____Coughing
___Difficulty smelling
____Flu (influenza)
____Fluid in lungs
____Hay fever
____Laryngitis
___Pleuritis
____Runny nose
____Respiratory inflammation
____Shortness of breath
____Sneezing
____Stuffy nose
____Tight around lungs
____Tuberculosis
____Trouble breathing out
____ Wheezing
Other_____
Are you congested frequently?

Which season is it worse and best?
What helps?

Mucous quality and/or color:
____Clear ____Thick/sticky ____Worse in the morning, ____Green
____Thin/runny afternoon, evening, night ____Yellow

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

Cough – check the symptoms which pertain to you

____Bloody
____Painful
____Dry cough
____Persistent
____Hacking
____Regularly
____Itchy throat
____Wet cough
____Worse at morning, afternoon, evening, night (circle)
____Triggers

Are there any other concerns you wish to share? Please use the space below to write anything else you feel may be important, and want us to consider during our consultation.

Breeze Botanicals Consent for Consultation & Disclaimer

Full name:_____
D.O.B _____

I may request that representatives of Breeze Botanicals perform a health and lifestyle evaluation and set up a program with lifestyle changes for the purpose of enhancing my health. I understand that natural health care is not intended as diagnosis, prescription, treatment or cure for any disease, mental or physical, and is not a substitute for regular medical care.

Article IX, U.S. Constitution "The enumeration in the Constitution, of certain rights, shall not be constructed to deny or disparage others retained by the People." Under the Ninth Amendment to the Constitution of the United States of America. I retain the right to freedom of choice in health care (or psychological services, or educational services, etc....). This includes the right to choose my diet and to obtain, purchase, and use any therapy, regimen, modality, remedy, or product recommended by the therapist, doctor or any practitioner of my choice. The enumeration in this declaration of these rights shall not be constructed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.

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

Disclaimer:

The information shared in Breeze Botanicals and by its representatives is not intended to treat, diagnose, cure or prevent disease. All information provided by Breeze Botanicals and its representatives is for informational purposes only and is not intended as a substitute for advice from your physician or other healthcare professional. Always consult with your healthcare provider prior to making any changes to your current health regimen. If pregnant or breastfeeding please consult with your physician before adding any supplements or herbs to your health plan. These statements have not been evaluated by the Food and

Drug Administration (FDA).

By signing this form I release Breeze Botanicals and its representatives of any liability.

_____Name (Please Print. Include parent/guardian name if minor)

Date:_____

_____
Signature (Parent/guardian signature if minor)

Date:_____

24 Hour Cancellation Policy

At Breeze Botanicals, we do understand that there are situations that may come up in people's day to day lives. While truly compassionate, Breeze Botanicals cannot absorb the consequences of last minute cancellations. We reserve specific times for each customer ensuring exceptional and individual care. To honor these relations, no exceptions can be allowed.

If an appointment is missed or cancelled with less than 24 hour notice, please be advised that a fee of 50% of the quoted consultation fee will automatically be charged.

Thank you,
Please sign below to consent to these terms:

_____
Date

_____
Signature

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