Descendant Botanicals

Informed Consent

I am an Herbal Apprentice practicing clinical hours for a nationally recognized herbal certification through the American Herbalist Guild. Currently, Herbalism is not considered a recognized health care modality in the state of Arizona. As such, there is no state licensing for herbal practitioners at this time. There is only national certification and registration, and all Holistic Health Consultations will be used to fulfill the requirements of the currently available certification process.

I am not a medical doctor, nor do I practice western medical assessment, diagnosis or treatment. I do not claim to cure disease, nor can I offer advice about the use of any pharmaceuticals or medications at any time. I encourage each client to openly communicate to their doctor before trying any new complementary health remedy.

My training includes scientific analysis of phytochemical components as well as the more subtle, energetic benefits of medicinal plants. The herbal recommendations provided do not replace medical care or medications prescribed by a licensed health professional.

In order to fulfill the certification guidelines, the focus of this holistic health consultation will be based on herbal & botanical preparations for therapeutic use. However because each client is uniquely individual, other health enhancing suggestions may be provided. Identifying and evaluating lifestyle patterns related to dietary wellness, exercise, and stress reduction are a part of the overall goal of a more holistic approach to health.

In order to provide specific recommendations for herbal consultation clients, I maintain a botanical medicinary. For the convenience and to ensure clients are receiving adequate individualized herbal formulas I will provide herbal remedies available for purchase. There is no obligation for any client to purchase these remedies, and I encourage everyone to seek out their own sources for herbal supplies.

A variety of adverse effects can arise when using herbal medicines, some are a part of the healing process, and some are the body's way of saying this particular plant is not the right remedy for an individual. Botanical preparations do not always effect people in the same way, and unforeseen reactions are common. If you experience any adverse reaction discontinue use immediately.

Again, I in no way claim to cure any disease or disorder. As an apprentice and student, my goal for practicing and sharing botanical medicine methods is to educate and inspire others to find wellness. The remedies suggested are meant to nourish the body, support organ systems, balance and detoxify when needed.

I have read, understand and agree with the above,

Name _____ Date _____

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Holistic Health Worksheet

Name_____
Age_____ Weight_____
Occupation_____

All information collected on this health evaluation will be kept completely confidential. Please be especially honest about personal medications as many common herbal medicines and prescription drugs interact.

Preferred Method of Contact
You may choose more than one ☺

- Email Address_____
- Phone # _____
- Text #_____
- Mailing Address _____

_____
_____

Please list any major health concerns, conditions, or complaints that you would like to be addressed in this consultation_____
_____
_____
_____

Please list any medications, supplements, or herbal remedies you are currently taking_
_____
_____

Do you have any allergies or sensitivities? _____
_____
_____

Have you ever been hospitalized, had any surgeries? Are you planning any upcoming surgeries, whether major or minor? _____
_____

Are there any other medical conditions you have dealt with? _____
_____

Are you pregnant or planning to become pregnant? (If applicable)_____

Have you ever been diagnosed with any of the following conditions?
Cancer_☐_ Diabetes_☐_ High Blood Pressure_☐_ Hepatitis_☐_ Seizures_☐_

Lifestyle Habits

Rate your average daily stress level from 1-10_____
Do you struggle with insomnia or the inability to relax? _____
How many hours of sleep you usually get per night? _____
Do you drink coffee or soda? How much, how often? _____
Do you smoke cigarettes? _____
Do you drink alcohol? _____ How often? _____
Do you have a history of drug abuse? _____

Dietary Habits

Do you crave sugar? _____ What kind of sweets do you enjoy? _____
_____
Do you crave salt? _____ What kind of salty foods do you enjoy? _____
_____
Do you crave specific foods? Which ones? _____
_____
How much water do you drink each day? _____
What is your primary source of drinking water? _____
What is the primary source of food you eat? For example; restaurants, fast food, prepackaged meals, or do you cook at home? _____
_____
_____
What are your favorite fruits? _____
What are your favorite vegetables? _____
How often do you eat vegetables? _____
What are your favorite snack foods? _____
_____
Are you currently practicing any kind of restrictive dietary system such as raw foods only, vegan/vegetarian, gluten free, dairy free, paleo, atkins, south beach, fat free, or an anti-inflammatory diet? _____
_____

Digestion

Do you experience any of the following symptoms?

Nausea ☐
Gas ☐
Indigestion ☐
Bad Breath ☐
Bloating ☐
Chronic or Frequent Constipation ☐
Hemorrhoids ☐
Blood in stool ☐
Food Cravings ☐
Poor Appetite ☐
Food Allergies or Sensitivities ☐
Chronic or Frequent Diarrhea ☐

Undigested food in stool ☐
Heartburn ☐
Diverticulitis ☐
Crohn's ☐
Frequent vomiting ☐
Hepatitis ☐
Gastric Reflux ☐
IBS ☐
Ulcerative Colitis ☐
Black Stools ☐
Celiac's ☐

Cardiovascular

High Blood Pressure ☐
Low Blood Pressure ☐
High Cholesterol ☐
Poor Circulation ☐
Pacemaker ☐
Anemia ☐
Chest Pains ☐
Palpitations ☐
Poor Circulation ☐
Heart Related Surgeries ☐
Fainting ☐

Respiratory

Asthma ☐
Chronic Cough ☐
Painful Breathing ☐
Frequent Colds ☐
Lung Disease ☐
Emphysema ☐
Excessive Mucous ☐
Frequent Bronchitis or Pneumonia ☐
Frequent Sinus Infections ☐
Seasonal Allergies ☐

Musculoskeletal

Neck Pain ☐
Head Pain ☐
Back Pain ☐
Muscle Pain ☐
Osteoporosis ☐
Fibromyalgia ☐
Muscle Weakness ☐
Joint or allover stiffness ☐
Arthritis ☐
Gout ☐
Rheumatic inflammation ☐

Urinary

Painful Urination ☐
Urinary Urgency ☐
Frequent Urination ☐
Frequent Bladder Infections ☐
Kidney Stones ☐
Blood in Urine ☐
Incontinence ☐
Prostate Problems ☐
Frequent Kidney Infections ☐
Kidney Disease ☐

Head, eyes, ears, nose, throat

Swollen Glands ☐
Canker Sores ☐
Cold Sores ☐
Chronic Dental Problems ☐
Blurred Vision ☐
Ringing in Ears ☐
Earaches ☐
Sinus Congestion ☐

Dizziness ☐
TMJ Disorder ☐
Frequent Sore Throat ☐
Poor Hearing ☐
Headaches ☐
Migraine Headaches ☐

Skin & Hair

Eczema ☐
Psoriasis ☐
Itching ☐
Rashes ☐
Slow healing of sores or wounds ☐
Very Oily Skin ☐
Frequent Fungal Infections ☐
Hair Loss ☐
Dandruff ☐
Hives ☐
Acne ☐
Very Dry Skin ☐
Boils ☐
Rosacea ☐

Endocrine

Hypothyroidism ☐
Hyperthyroidism ☐
Adrenal Fatigue ☐
Low Testosterone ☐
Chronic Fatigue ☐
Hashimoto's ☐
Grave's Disease ☐
Diabetes ☐
Low Estrogen ☐
Mental Sluggishness/Brain Fog ☐

Mental Health

Anxiety ☐
Depression ☐
ADD/ADHD ☐
Eating Disorder ☐
Excessive Fear ☐
Excessive Anger ☐
Bipolar/Manic Depressive ☐
Post Traumatic Stress Disorder ☐
Schizophrenia ☐
Obsessive Compulsive Disorder ☐
Chronic Irritability ☐
Loss of Memory ☐

Please **circle** any immediate family's health history; diabetes, cancer, heart conditions, mental illness, asthma, gout, epilepsy, thyroid problems, other _____

Current State of Emotions & Feelings (major stress, depression, etc.) _____
_____

Have you ever been diagnosed with an auto-immune disease? (Such as rheumatoid arthritis, lupus, psoriasis, etc…_____
_____

Is there any other important health related information you would like to add? _____
_____
_____
_____

Name _____ Date _____

Female Topics (If applicable)

Age of first menses ____ Cycle Length _____
Regular or Irregular Cycles? _____ Heavy or Light Flow? _____
Do you keep track of your cycle? _____

Premenstrual Symptoms

Food Cravings ☐ Breast tenderness/pain ☐
Mood Swings ☐ Insomnia ☐
Headaches ☐ Skipped Periods ☐
Cramping ☐ Pain at Ovulation ☐
Bloating ☐ Breast Lumps or Cysts ☐
Nausea ☐

Gynecological Symptoms

Ovarian Cysts ☐ Ovarian Cancer ☐
Uterine Fibroids ☐ Uterine Cancer ☐
Pelvic Inflammation ☐ Breast Cancer ☐
Endometriosis ☐ Cervical Cancer ☐
Sexually Transmitted Diseases ☐ Abnormal Discharge ☐
Vaginitis ☐

Menopausal Symptoms

Hot Flashes ☐ Vaginal Dryness ☐
Night Sweats ☐ Headaches ☐
Insomnia ☐ Heavy Bleeding ☐
Weight Gain ☐ Frequent Urination ☐
Memory Problems ☐ Mood Swings ☐
Depression ☐ Fatigue ☐

Are you currently using Hormone Replacement Therapy or Bio-Identical Hormones?
_____ If so what kind? _____

Pregnancy History

How many pregnancies? ____ Any high risk pregnancies? _____
Where there any complications? _____
History of Miscarriage? _____
Infertility Issues? _____ Known Cause? _____
_____
Any past abortions? _____
Are you currently on birth control medications? _____
Are you currently trying to become pregnant? _____