

Welcome to Fern Life Center. Please fill out all pages entirely so we may serve your medical needs. This one time inconvenience is essential and appreciated.

Date: \_\_\_\_\_ Client Name: \_\_\_\_\_ Address: \_\_\_\_\_ City/Zip \_\_\_\_\_

Gender(M/F): \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Partner Status (S/M/W/D): \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer phone: \_\_\_\_\_ Spouse Name: \_\_\_\_\_ Spouse birthdate: \_\_\_\_\_

Spouse SS#: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_ Name of insured party: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_ ID# \_\_\_\_\_ Group#: \_\_\_\_\_

In case of emergency please contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Pager: \_\_\_\_\_

Name of other medical providers and phone/address info: \_\_\_\_\_

Assignment and Release: I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Fern Life Center all insurance payments, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions:

(signature) \_\_\_\_\_ date: \_\_\_\_\_

#### Rights and Responsibilities

**Our Promise to you:** Our mission is to empower you, our client to learn to recognize the patterns of behavior that inform your wellness choices. We thank you for allowing us to journey with you on this path to transformation and look forward to growing with you!

**Your Responsibilities:** We ask for a 24-Hour notice of cancellation. Less than 24 hr. notice will require a \$50.00 re-scheduling fee. Payment is due on the day of initial consultation unless arrangements are made for automatic deduction payments. It is your responsibility to find out if your insurance covers massage and medical visits. Our Pancha karma therapy is not covered by insurance and half of the total cost is due when the appointment is made and the other half is due at the conclusion of therapy. Neither colon hydrotherapy nor skin care services are covered by insurance. Please be prepared to pay in full for all services rendered at the time of service.

Client Signature: \_\_\_\_\_ date: \_\_\_\_\_

Medical Provider: \_\_\_\_\_ date: \_\_\_\_\_

**CHIEF HEALTH CONCERNS**

What are your main health concerns at this time? Order by importance to you:

- 1.
- 2.
- 3.
- 4.

What would you like to get out of this consultation today?

- 1.
- 2.
- 3.

What do you think you need to heal?

**PAST MEDICAL HISTORY**

Include major conditions, dates of treatment and procedures performed.

1. Serious illnesses: \_\_\_\_\_

2. Hospitalizations: \_\_\_\_\_

3. Surgeries: \_\_\_\_\_

4. List other pertinent past or current conditions: \_\_\_\_\_

5. Have you been under the care of a licensed health care professional in the past year?  Yes  No

6. If so, for what reasons: \_\_\_\_\_

7. Is there any possibility that you are pregnant?  Y  N

**Medication/Supplement/Herbal/Vitamin History**

Name	Doseage/Freq	How long Taken?	What for?	Who Prescribed?

**Pharmacy&phonenumber:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

## FAMILY HISTORY

List illnesses that have occurred in your blood relatives including: cancer, high blood pressure, heart disease, renal disease, TB, bleeding tendencies, diabetes, stroke, mental disease, drug or alcohol addiction, glaucoma

Family Member	Current Age	Diagnosis	Age at Diagnosis	Current Health or age at death
Father				
Mother				
Paternal G'Father				
Paternal G'Mother				
Maternal G'father				
Maternal g'mother				
siblings				
siblings				
children				
children				
children				

Immunizations and Reaction: \_\_\_\_\_

Date of last physical exam, pap smear, PSA, lab work: \_\_\_\_\_ Last Dental exam: \_\_\_\_\_

## Adrenal Health: Section A

### 1 pt for each yes

1. Do you frequently have low body temperatures? (<98 degrees F) Y N
2. Do you frequently get irritable? Y N
3. Do you have poor memory or concentration? Y N
4. Do you notice palpitations? Y N
5. Do you suffer from allergies or asthma? Y N
6. Do you bruise easily or find your wounds heal slowly? Y N
7. Do you get frequent/chronic infections? Y N
8. Do you have dry, thinning skin? Y N
9. Do you get headaches? Y N
10. Do you have unexplained hair loss? Y N
11. Do you skip meals? Y N
12. Do you exercise more than one time each week? Y N
13. Do you have thyroid problems? Y N
14. Is your energy good all day? Y N
15. Do you need caffeine in the morning or after lunch? Y N

**3 points for each yes**

16. Are you emotionally overstressed? Y N
17. Do you get tenderness across your lower back? Y N
18. Do you suffer from depression or down moods? Y N
19. Do you have low blood pressure? Y N
20. Do you experience a "second wind" (high energy) at bedtime? Y N
21. Do you experience chronic or recurrent inflammation? Y N
22. Do you get light headed when sitting up or standing? Y N

**5 points for each yes (yes to any of these triggers an adrenal test)**

23. Do you suffer from chronic pain? Y N
24. Do you suffer from low blood sugar/hypoglycemia? Y N  
(i.e. headaches, sleepiness, mood swings if skipping meals)
25. Do you suffer from insomnia? Y\* N
26. Do you experience symptoms of PMS? Y\*\* N  
(breast tenderness, abdominal cramping, heavy periods, mood swings)
27. Are you menopausal or peri menopausal? Y\*\* N  
(skipped periods, between 45-55 yrs old, hot flashes, vaginal dryness)

**If your score >10 you probably have some degree of adrenal dysfunction**

**If your score >20 it is highly probably you have adrenal dysfunction**

**If your score >30 it is nearly certain you have adrenal dysfunction**

\*If you answered yes to question 25, please also complete [Section B - Insomnia](#)

\*\*If you answered yes to questions 26 or 27, please also complete [Section C - Female Hormones](#)

### Section B-Insomnia

1. Do you experience difficulty falling asleep? Y N
2. Does your mind race when you are trying to go to sleep? Y N
3. Does it take you more than 20 minutes to fall asleep once lights off? Y N
4. Do you experience a second wind (high energy) at night? Y N
5. Do you have trouble staying asleep? Y N
6. Do wake more than once per night? Y N
7. Do you have trouble going back to sleep once awakened? Y N
8. Do you frequently waken between 2-3am? Y N
9. Do you experience restless legs when trying to sleep? Y N
10. Do you recall your dreams? Y N
11. Do you have vivid or disturbing nightmares? Y N
12. Do you sleep/nap during daylight hours? Y N
13. Do you feel groggy or sleepy when you awaken? Y N
14. Do you work "third shift" (work nights/sleep days)? Y N
15. Are you depressed when weather is cloudy or overcast? Y N
16. Are you taking any sleep pills, natural or prescription? Y N
17. Do you snore? Y N
18. Have you ever been diagnosed with sleep apnea? Y N
19. Do you use coffee, caffeine, or other stimulants/medications? Y N
20. Do you have children or pets that sleep in your room/bed? Y N
21. Do you exercise late in the day? Y N
22. Do you eat carbohydrate snacks before bed (cake, cookies, ice cream)? Y N
23. Do you eat nothing between dinner and bedtime? Y N
24. Do you drink alcohol at night? Y N
25. Do you have sinus problems/allergies/asthma that is worse at night? Y N
26. Does your sleep partner snore or keep you awake due to restlessness? Y N
27. Have you ever had a concussive injury (black out due to head trauma)? Y N
28. Is your insomnia related to your cycle? Y N
29. Are you menopausal or have you had a hysterectomy? Y N

### Section C-Female Hormones

#### Pre & Peri Menopausal Women:

(425) 391-fern (3376) ● fax: (425) 391-3378 ● [www.FernLifeCenter.com](http://www.FernLifeCenter.com) ● 410 NW Newport Way, Suite B. Issaquah, WA 98027

- Do you experience frequent or irregular periods/menstruation? Y N
- Do you experience severe abdominal cramping with your period? Y N
- Do you get breast tenderness around the time of your periods? Y N
- Do you get moody or irritable during or just before your period? Y N
- Do you get heavy periods (heavy bleeding more than 2-3 days)? Y N
- Do you have uterine fibroids? Y N
- Do you have trouble getting to sleep because your mind is racing? Y N
- Have you had trouble getting pregnant or experienced a miscarriage? Y N
- Do you get anxiety or panic attacks? Y N
- Do you take or have you taken birth control pills in the past 2 years? Y N
- Have you gone without a period for more than 3 months? Y N
- Have you experienced depression or post partum depression? Y N
- Do you get headaches/migraines around the time of your period? Y N
- Do you get cravings for sugar, fat, salt, or chocolate? Y N
- Do you experience pain during intercourse? Y N
- Do you get bloating and water retention during around your period? Y N
- Do you take birth control pills, patches, injections, or hormone-types? Y N
- Do you have a family history of breast, uterine, or ovarian cancer? Y N
- Do you have endometriosis? Y N

**Post Menopausal Women:**

- Was your last menstrual period more than one year ago? Y N
- Do you get "hot flashes" Y N
- Do you get severe sweating at night? Y N
- Do you have vaginal dryness? Y N
- Have you noticed vaginal thinning? Y N
- Do you notice a reduced libido? Y N
- Are you concerned for osteoporosis or hip/spinal fractures? Y N
- Do you have trouble getting to sleep because your mind is racing? Y N
- Do you get anxiety or panic attacks? Y N
- Do you experience pain during intercourse? Y N
- Do you take hormone replacement (pills, creams, patches, ect)? Y N
- Do you have a family history of breast, uterine, or ovarian cancer? Y N
- Have you had a hysterectomy? Y N

**Final Score:** \_\_\_\_\_

***Environmental history***

Please check mark if your work or home environment expose you to the following and describe:

stress\_\_\_heavy lifting\_\_\_hazardous substances\_\_\_structure built before 1975\_\_\_mold\_\_\_asbestos\_\_\_loud noise\_\_\_second hand smoke\_\_\_radiation\_\_\_air pollution\_\_\_motor vehicle emissions\_\_\_pesticides\_\_\_sun and UV light\_\_\_carbon monoxide\_\_\_chemicals\_\_\_recent travel outside the U.s.\_\_\_born outside the u.s.\_\_\_eaten in fast food restaurant in last 2 weeks\_\_\_exposed to infectious persons in past 2 weeks\_\_\_

**Toxicity Questionnaire**

This questionnaire gives us an indication of your toxicity level based on common signs and symptoms related to toxicity.

**Point Scale:**

- 0 = Never or almost never have the symptom
- 1 = Occasionally have it, effect is not severe
- 2 = Occasionally have it, effect is severe
- 3 = Frequently have it, effect is not severe
- 4 = Frequently have it, effect is severe

**HEAD**

- Headaches
- Dizziness
- Insomnia
- Faintness
- TOTAL

**EARS**

- Itchy ears
- Ringing in ears/ loss of hearing
- Earaches/ ear infections
- Drainage from ear
- TOTAL

**EYES**

- Bags or dark circles under eyes
- Watery or itchy eyes
- Swollen, reddened, or sticky eyelids
- Blurred or tunnel vision (excluding near- or far- sightedness)
- TOTAL

**NOSE**

- Stuffy nose
- Sinus congestion, sinus infection
- Constant sneezing
- Hay fever/allergies
- Excess mucus formation
- TOTAL

**MOUTH/THROAT**

- Chronic coughing
- Sore throat, hoarseness, loss of voice
- Gagging, frequent need to clear throat
- Swollen tongue, gums, or lips
- Swollen lymph nodes
- Canker sores, mouth ulcers
- TOTAL

**HEART**

- Chest pain
- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- TOTAL

**LUNGS**

- Asthma, bronchitis
- Chest congestion
- Shortness of breath
- Difficulty breathing
- TOTAL

**SKIN**

- Acne or brown "age/liver spots"
- Hives, rashes, cysts, boils
- Eczema or psoriasis
- Itchy skin/dermatitis

- Hair loss, hair thinning
- Body odor
- Excessive sweating
- TOTAL

**JOINTS/MUSCLES**

- Pain or aches in joints or lower back
- Stiffness or limitation of movement
- Arthritis
- Pain or aches in muscles
- TOTAL

**MENTAL/EMOTIONAL**

- Poor memory
- Difficulty concentrating
- Mood swings
- Depression
- Anxiety, fear, or nervousness
- Anger, irritability, or aggressiveness
- Insomnia
- TOTAL

**ENERGY LEVEL**

- Fatigue/low energy
- Restlessness
- Hyperactivity
- Feeling of weakness
- TOTAL

**WEIGHT**

- Underweight
- Overweight
- Difficulty losing weight
- Crave certain foods
- TOTAL

**OTHER**

- PMS
- Frequent colds, flus
- Chemical or environmental sensitivities
- Food allergies/sensitivities
- TOTAL

Please add the numbers from each section and write the section total in the spaces provided, then add all the section totals together and put that total in the space below.

\_\_\_ GRAND TOTAL

**Interpreting Your GRAND TOTAL Toxicity Score:**

- 15 or lower: You have a low level of toxicity.
- 16 to 49: You have a moderate level of toxicity.
- 50 or higher: You have a high level of toxicity.

**Health Habits and Daily Routine**

Check which substances you use and describe what kind, how much and how often:

Caffeine \_\_\_\_\_ Soda \_\_\_\_\_ Milk \_\_\_\_\_ Alcohol \_\_\_\_\_

Tobacco (include history and date quit) \_\_\_\_\_ Drugs \_\_\_\_\_

Other beverage types and amounts (juice, water, herbal teas) \_\_\_\_\_

If you drink alcohol:

Have you ever felt you should cut down: \_\_\_\_\_ Have people ever annoyed you by nagging you about your drinking? \_\_\_\_\_ Have you ever felt guilty about drinking? \_\_\_\_\_ Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? \_\_\_\_\_

### DIETARY HABITS

This section will give us information about your eating habits. There are no “right” or “wrong” answers. Accurate and thoughtful responses will allow us to pinpoint your good habits as well as the habits that you might consider changing.

- Use the past month as your standard for how you eat.
- Recall the times during the day when you ate, and what you had.
- Include snacks and “nibbles” as well as meals and beverages.
- If you ate out regularly or traveled, remember to include those foods too.
- Be sure to answer every item on this form. If you did not eat a food listed below, or ate it less than once a week, write a “0” in the space provided. Please do not leave blanks.

For each of the foods listed, please indicate how many servings per week you usually ate in the past month. (If you ate a food less than once a week, write a “0” in the space provided.) Where indicated, check whether your servings are large, small, or about average in size.

Food Item	Average Weekly Serving	Serving Size Sm., Med., or Large	Average Serving Size
Red Meat			4 oz.
Turkey or Chicken			1 large piece or 2 smaller pieces
Fish (including canned in water)			4 oz or ½ can
Shellfish (including canned in water)			4 oz or ½ can
Bacon or sausage			2 pieces
Meat Dishes (casseroles, tacos, pizza, meat sauce)			1 cup casserole, 1 taco or pizza slice
Luncheon Meats (salami, bologna, hot dogs, etc. including turkey and chicken varieties)			1 piece
Low Fat Luncheon Meats (at least 95% fat free)			1 piece
How many of the above servings are from fast food outlets? (McDonald’s, Taco Bell, etc.).			4 ounces of meat or fish is roughly the size of a deck of cards.
Soy-Meat Substitute (protein drink)			Package directions
Whey meal substitute			8 oz glass
Whole eggs or egg yolks			1 egg or yolk
Cheese or cream cheese			1 oz or 1 slice
Ice cream			½ c or 1 scoop
Fruit juice			½ c or 4 oz
Fruits, fresh or dried			1 whole piece or 1 cup cut-up fruit
Milk, yogurt or cottage cheese			1 cup (8 ounces)

Vegetable salads or raw vegetables			1 cup
Cooked vegetables (fresh, frozen, or canned)			½ c
corn			½ c
"Healthy" cereals (whole grain, oatmeal, etc)			1 med. bowl
Sugary cereals			1 med. bowl
Salad dressings			2 TBSP
Nuts, nut butters (like peanut butter)			2 TBSP
mayonnaise			1 TBSP
Chips or French fries			1 cup
Baked desserts and pastries (cake, cookies, etc.)			1 piece or 2 cookies
Coffee Beverages and Tea			1 cup
Donuts or sweet rolls			1 piece
Chocolate or candy bars			1 bar
Alcoholic drinks			1 drink, 1 can beer, 1 glass wine
Spaghetti, noodles or other pastas			1 cup
Dried beans, split peas or lentils			¾ c cooked
potatoes			¾ c or 1 potato
rice			¾ c
Bread, bagels, rolls, tortillas, English muffins			1 piece
Biscuits, bakery muffins, croissants, flaky rolls			1 piece or slice
Sweetened beverages, including diet drinks (soft drinks, fruit drinks, etc.)			1 large glass, 1 can

For each of the following items, check the one answer that best describes you. Use your eating habits of the past month as your standard.

How many meals do you eat out per week? \_\_\_\_\_ How many glasses of water do you consume each week? \_\_\_\_\_

On average, how often do you eat breakfast in a week? \_\_\_\_\_ Are there any foods that you avoid because you have a reaction to them? \_\_\_\_\_

How often do you choose organic foods?

Always \_\_\_\_\_

Sometimes \_\_\_\_\_

Never \_\_\_\_\_

When I eat meat, fish or poultry,

1 I almost always have it fried or cooked with oil or another fat, or with gravy.

2 I almost always have it broiled, baked, or stewed, and without any gravy or fat.

3 I do both.

4 I don't eat meat, fish or poultry.

When I eat cooked vegetables,

1 I almost always have them with butter, margarine or sauce; or cooked with butter, margarine, oil, or another fat.

2 I almost always have them without any of the fats listed above.

3 I do both.

4 I don't eat cooked vegetables.

Are there any routines around eating?:

Any current or past problems with chronic eating disorders or other food related issues?  Y  N

Do you have allergic reactions to any foods? If yes, please list:

**DAILY SCHEDULE** (include approximate times)

Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities).

	Time	Routine	Activity	Variation	Spiritual Practices	Exercise	Foods Eaten
Morning							
Mid-Morning							
Lunch							
Mid-Afternoon							
Evening							
Late Evening							
Night							
Middle of the Night							

Are you sexually active? Y  N  Frequency? \_\_\_\_\_ Have you ever contracted a sexually transmitted illness? \_\_\_\_ If so, what and when? \_\_\_\_\_ Method of birth control: \_\_\_\_\_

Do you exercise regularly?  Y  N Length of time: \_\_\_\_\_ Times per week: \_\_\_\_ Type(s) \_\_\_\_\_

Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite): \_\_\_\_\_

Body temperature: Do you generally run warm or cold? Please explain: \_\_\_\_\_

**Birth History**

Birth: Premature \_\_ Breathing problems \_\_ Time of birth \_\_ Infections \_\_ Breech \_\_ C-sec. \_\_

Childhood: Place lived \_\_ Illnesses \_\_ Breastfed \_\_ Formula \_\_ Colic \_\_ Milk allergy \_\_

**Review of Systems**

Check all symptoms that are of concern to you at this time that you want to discuss with the practitioner. Please indicate any area in which you have experienced a severe episode and indicate if episode was in previous 6 months or prior to 6 months time.

Past	Present	HEAD
		Headaches
		Dizziness
		Fainting spells
		Loss of balance
		Difficulty remembering
		Difficulty thinking clearly
		Thinning or loss of hair

Past	Present	MOUTH
		Excessive thirst
		Loss of taste
		Strange taste
		Bad breath
		Lip ulcers or lesions
		Dry/cracking lips
		Tongue pain
		Bleeding gums
		Receding gums

Past	Present

**EARS**

- Hearing loss
- Ringing
- Earaches-Pain
- Discharges
- Bleeding


- Tooth pain
- TMJ

Past	Present

**EYES**

- Pain-soreness in eyes
- Redness
- Burning
- Mucous
- Dryness
- Itching
- Tic/twitch
- Blurred/loss of vision

Past	Present

**NECK**

- Pain
- Swollen glands
- Lumps
- Stiffness

Past	Present

**NOSE**

- Loss of smell
- Bleeding
- Pain
- Discharge
- Post-nasal drip
- Sinus Congestion

Past	Present

**CARDIOVASCULAR/PULMONARY**

- Pain in chest
- Tightness/pressure in chest
- Heart palpitations/irreg HR
- Painful/difficult or Shortness of breath
- Decreased Endurance
- Persistent cough
- Frequent chest colds

Past	Present

**DIGESTION**

- Pain
- Burning indigestion
- Belching
- Regurgitation
- Vomiting
- Excessive Gas
- Heavy-Bloaty after eating
- Hemorrhoids
- Constipation (< 1 BM/day)
- Diarrhea
- Both constipation & diarrhea
- Bloody Stool

Past	Present

**SKIN**

- Dry-flakey
- Rashes
- Blisters
- Acne
- Changing or bleeding moles
- Response to insect bites

Past	Present

**CIRCULATION**

- Varicose veins
- Cold hands-feet
- Swollen ankles
- Calf pain
- Puffy eyes

Past	Present

**FEMALE SYSTEM**

- Irregular cycle
- Heavy/prolonged bleeding
- Vaginal discharge
- Painful menses
- Missed menses or Spotting

Past	Present	
		<b>GENITO-URINARY</b>
		Loss of urinary control
		Painful urination
		Frequent urination
		Urinary retention, dribbling
		Frequent night urination
		Blood in urine
		Pain in kidney/groin area
		Kidney/bladder infections
		Difficulty starting stream

Past	Present	
		<b>MUSCLES&amp;JOINTS</b>
		Swelling in joints
		Pain/ache in joints
		Stiff joints
		Persistent muscle/bone pains
		Tremors/tics in muscles
		Muscle weakness/atrophy
		Numbness

Past	Present	
		<b>NERVES</b>
		Loss of taste, smell or touch
		Tingling sensations
		Tremors in limbs
		Uncoordinated muscle/limbs

		Discharge
		PMS or Menopausal symptoms
		Pregnancies #
		Miscarriages/abortions #
		Unsatisfactory sex/change in libido
		Genital sores
		Ovarian cyst
		Fibroids
		1 <sup>st</sup> menstrual period date and last menstrual pr. date

Past	Present	
		<b>BREASTS</b>
		Swelling
		Redness
		Lumps
		Nipple discharge
		Tenderness-pain

Past	Present	
		<b>MALE SYSTEM</b>
		Prostate gland swollen/painful
		Low sperm count
		Low motility
		Genital sores or lesions
		Genital discharge
		Erectile function difficulty
		Change in libido

Please take a few minutes to go inside of yourself to answer these last questions so that we may better design a program to fit your unique needs. Thank you for your careful consideration. It is very much appreciated.

1. What are you doing in your life now that brings you peace and harmony?
2. What do you want your spiritual life to look like?
3. What does your spiritual life currently look like?
4. If you could design your perfect state of wellness and balance, what would your life look like?
5. What would you have to give up to achieve this life?
6. How can we best support you to meet your dreams?
7. What does it look like when you are spiraling down emotionally?
8. How do you bring yourself back out?
9. Have you noticed patterns that repeat themselves in your life (only the names, places and occurrences have changed names)?
10. Do you know your purpose in life?
11. Do you have vivid dreams?
12. Please assign a number value to your satisfaction with the following areas of your life; 1 is low and 10 is the highest:  
Physical environment\_\_\_ Career\_\_\_ Fun and Recreation\_\_\_ Health\_\_\_ Money\_\_\_ Romance/Significant other\_\_\_  
Personal Growth\_\_\_ Friends/Family\_\_\_