# Mark Shanagher – Herbalism & Healing

**Health Questionnaire**

Please fill this form in as thoroughly as possible.

All the medical information contained here is confidential will not be released to any person except with your written permission. Please bring relevant medical results and information with you to the consultation.

**Personal details**

Surname: ..... Date: .....

Forename(s): ..... Gender: ….....

Date of Birth: ..... Age: .....

Email: ..... Place of Birth: .....

Tel No: ..... Address: .....

Occupation: ..... .....

Doctor & Surgery: .....

Nearest Relative inc Tel Number: .....

Marital status: O Single O Married O Relationship O Separated O Children (Ages)

Living/ Housing Situation: .....

Ancestry: .....

Primary Health Objective:

Secondary Health Objective:

**Current health** Reason for visiting:

| Condition | Symptoms | Duration |
|---|---|---|
| | | |
| | | |
| | | |

**Health record**

Past serious illnesses, medication & treatment:

| Condition | Date | Treatment | Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Weight: ..... Height: .....

Blood Type: .....

Have you taken many antibiotics? If yes what for and when?

Are you being treated by any other practitioner at the moment? If yes please list details:

**Family health** Family or hereditary conditions:

| | |
|---|---|
| Mother | |
| Father | |
| Grandparents (Mother's side) | |
| Grandparents (Father's side) | |
| Siblings | |

**Current supplements**

| Name | Brand | What is it for? | Strength | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Current medications**

| Name | Brand | What is it for? | Strength | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Lifestyle** What is a typical daily routine?

| Activity | Time | What do you do/ eat? |
|---|---|---|
| Wake Up | | |
| Morning Routine | | |
| Breakfast | | |
| Snacks | | |
| Lunch | | |
| Snacks | | |
| Dinner | | |
| Evening | | |
| Going to Bed | | |

**Exercise** Please write down what you do for exercise in the week:

**Hobbies & Special Interests:**

**Spiritual/ Religious affiliation**:

**Mind and emotions** How do you feel about the following areas of your life?

Home:

Work:

Social:

Sex:

Other:

What are your strengths?

What are your weaknesses?

Are there any emotional issues you have in terms of family, work and social relationships?

What special ambitions or desires do you have?

Are you able to express your feelings and emotions easily? O Yes O No

What causes stress in your life?

Do you have tools or techniques to relieve stress? O Yes O No

If Yes what are they?

If there is one thing in your life that you would like to change right now, what is it?

What is/ are the predominant emotion(s) in your life?

What is your memory like?

**Diet** For the following foods please list percentage in your diet:

| Raw food | 'Junk' food | Meat | Fish | Dairy | Vegetables | Cooked food | Pastries/ Biscuits |
|---|---|---|---|---|---|---|---|
| .....% | .....% | .....% | .....% | .....% | .....% | .....% | .....% |

Do you cook your own food? O Yes O No .....%

How much water do you drink? ..... glasses/day

Do you drink alcohol? O Yes O No If yes, what types? (Spirts, Beer) .....

How often? .....Times/week

Do you drink coffee? O Yes O No How much? ..... cups/day

Do you drink tea? O Yes O No How much? ..... cups/day

Do you drink soft drinks? O Yes O No How much? ..... cups/day

Do you smoke tobacco? O Yes O No How much? .....per day/ per month

Do you take recreational drugs? O Yes O No Which ones? ….....

How often? ….....

Are you vegetarian? O Yes O No If yes since when .....

Are you vegan? O Yes O No If yes since when .....

**Digestion** Is your appetite (sensation of hunger):

O Erratic O Sluggish O Good O Too Good O Balanced O Do you get very thirsty?

Do you suffer from:

O Wind or bloating O Heartburn O Nausea O Bad breath O Bleeding gums O Ulcers

O Irritable Bowel Syndrome O Abdominal pain O Liver problems O Gallstones

O Food intolerances. If yes what?

**Elimination Bowels**

Do you have a daily bowel movement? If yes please tick: O -1 O 1 O 2 O 3 O +4

Do you have constipation? O Yes O No If yes how long for? .....

Do you have haemorrhoids? O Yes O No

Do you have diarrhoea? O Yes O No

If yes, please describe colour, odor, time of day.

Do your stools:

O Show blood O Sink O Have Mucus O Float O No odor O Have a bad odor

Do you suffer pain when passing stool? O Yes O No If yes, what type? .....

What shape are your stools? .....

What colour are you stools? .....

**Urination** Please tick boes that apply to you:

No. of urinations/day: ..... Is the colour: O Cloudy O Red O Pale O Yellow

O Do you urinate at night? O Water retention O Interstitial cystitis

O Painful urination O Frequent urination O Blood in urine

O Urgency of urination O Kidney/bladder stones O Burning urine

O Decrease in flow O Prostate enlargement O Irregular flow

O Difficulty stopping or starting O Inability to hold urine

**Immunity** Do you suffer from any of the following conditions?

O Cystitis O Cold sores O Nasal drip O Thrush O Eczema O Inflammation

O Psoriasis O Hay fever O Candida O Migraine O Irritable Bowel O Asthma

O Other .....

Do you have strong immunity? .....

How many colds/flu do you get a year? .....

**Metabolic vitality** Please tick boes that apply to you:

O Erratic energy O Night sweats O Frequent fevers

O Chronic fatigue O Slow metabolism O Chills

O Sudden energy drops O Do you generally feel tired? O Recent weight gain

O Do you feel hot? O Intolerance to heat or cold O Recent weight loss

O Do you feel cold? O Excessive thirst O Do you sweat easily?

O Are you muzzy headed in the morning?

When is your energy best? O Morning O Midday O Afternoon O Evening

What would you say is your energy level? Low 0 – 10 High .....

**Heart**

Is there a history of heart disease in your family? O Yes O No

Do you have palpitations? O Yes O No When? ….....

Do you eat high fat foods or red meat? O Yes O No

What is your Blood Pressure? ..... O High or O Low blood pressure

What is your cholesterol level? HDL ..... LDL ..... Triglycerides .....

Do you suffer from:

| | | |
|---|---|---|
| O Chest/heart pain | O Fainting | O Irregular heart beat |
| O Cold hands or feet | O Ankle swelling | O Palpitations |
| O Easy bruising | O Varicose veins | O Blood clots |

**Skin and Hair** Do you suffer from:

| | | |
|---|---|---|
| O Rashes | O Hives | O Eczema |
| O Poor healing sores | O Itching | O Psoriasis |
| O Acne | O Dandruff | O Hair loss |
| O Recent moles | O Recent changes in skin texture | O Visible broken veins |

Any other noted problems with your skin, nails or hair?

**Head, Eyes, Ears, Nose and Throat** Do you suffer from:

| | | |
|---|---|---|
| O Poor vision | O Blurred vision | O Ringing in ears |
| O Floaters | O Eye pain | O Sore throat |
| O Cataracts | O Earaches | O Canker sores |
| O Glaucoma | O Poor hearing | O Grinding teeth |
| O Facial pain | O Jaw pain | O Dizziness |
| O Mucous in throat | O Nosebleeds | O Cold sores, if yes how often? |
| O Swollen glands | O Frequent colds | |

Any other problems with your head, eyes, ears, nose or throat?

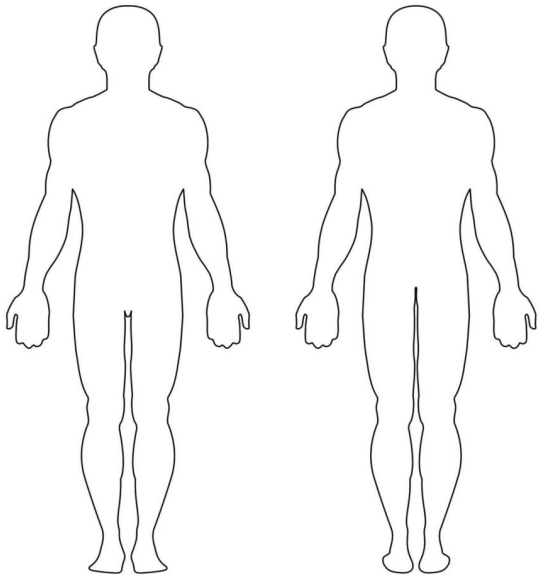
**Respiration**

| | | | |
|---|---|---|---|
| Have you ever had breathing difficulties? | O Yes | O No | |
| Do you wheeze? | O Yes | O No | Cause?..... |
| Do you cough mucus? | O Yes | O No | When and colour? ..... |
| Do you regularly have a blocked nose? | O Yes | O No | |

**Pain**

Do you have any pain(s)? O Yes O No

Please indicate painful or distressed areas below:



| Area/ Description of Symptoms | Pain Level: Low 1 – 10 High | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

**Musculoskeletal** Please tick that which applies to you:

| | | |
|---|---|---|
| O Neck pain | O General muscle pain | O Muscle weakness |
| O Shoulder pain | O General stiffness | O Broken bones |
| O Joint pain | O Back pain | O Reduced movement |

**Eyes**

Colour: O Brown - O Light or O Dark O Green O Blue

Sclera: O Yellow O Red O White

**Men's reproductive health** Do you suffer from:

| | | |
|---|---|---|
| O Excess urination | O Low libido | O Excess libido |
| O Infertility | O Impotence | O Prostate enlargement |

**Women's reproductive health**

Date of last period ..... Cycle length .....

How many days does your period last?.....

Do you suffer from:

O Pain When and please describe? .....

O Migraines at menstruation When?.....

O Food cravings What?.....

O Breast distension

O Clots If yes, what size? O Smaller than a pea O Larger than a pea

O Low libido

O Excess libido

Colour of blood: O Light red O Medium red O Dark red

Do you suffer from PMS? What happens?

| | | |
|---|---|---|
| O Low libido | O Fatigue | O Poor memory |
| O Anxiety | O Dizziness | O Grief |
| O Nervousness | O Headaches | O Confusion |
| O Mood Swings | O Breast tenderness | O Insomnia |
| O Nervous tension | O Bloating | O Lower back pain |
| O Craving for sweets | O Weight gain | O Abdominal pain |
| O Increased appetite | O Water retention | O Joint pain |
| O Palpitations | O Depression | O Headaches |

Type of contraception:

Do you or have you recently used contraceptive pill? O Yes O No

If yes, which one? .....

Do you use: O IUD O Condoms O Diaphragm

For how long? .....

Are you pregnant? O Yes O No Are you trying to conceive? O Yes O No

How many pregnancies? …..... Do you have children? O Yes O No

Age during (if applicable): Menarche..... Pregnancy..... Menopause.....

Have you had / do you have?

| | | |
|---|---|---|
| O Hysterectomy | O Fibroids | O Herpes |
| O Irregular PAP smear | O Ablation | O D&C |
| O Interstitial cystitis | O Irregular bleeding | O Pain with intercourse |
| O Dryness with intercourse | O Infertility | O Breast cancer |
| O Mastectomy | O Lumpectomy | O Yeast infections |

**Sleep**

Do you get to sleep easy? O Yes O No

Do you feel rested when you wake up? O Yes O No

Do you wake up in the night? O Yes O No If yes, what time? .....

Average no of hours sleep per night .....

What are your dreams like?

**For diagnosis only**

Voice:

Appearance:

Composure:

**Tongue**

Colour: Pale Red Deep Red Purple Blue

Coating: Thick None White Yellow Grey/ Black

Moisture: Wet Dry Creamy/Greasy

Shape: Thin Swollen Stiff Flaccid Long Short Cracked Trembling
Crooked Curled up Sides Red Spots Swollen Sides

Tongue diagram:

**Pulse**

Designation: Floating Wiry Soft Leathery Leekstalk Sinking Deep Hidden Taut

Frequency: Fast Agitated Slow Leisurely Choppy Slippery Tight

Width: Big Thready

Strength: Full Flooding Weak Feeble Scattered

Length: Short Long

Rhythm: Accelerated Uneven Knotted

| | | | |
|---|---|---|---|
| LHS: | SI | Gb | Bl |
| | Ht | Liv | KYn |
| RHS: | LI | St | TW |
| | Lu | Sp | Kyg |

**Diagnosis**

Yin/ Yang Full/ Empty Hot/ Cold Int/ Ext Damp/Dry

Qi Blood Fluids

6 Stages 4 Levels

5 Elements Triple Burner

Zang-Fu

Pathogenic Factors

Channel

Disease Cause

Vikriti: V P K Prakriti: V P K

Dhatu: Rasa Rakta Mamsa Meda Asthi Majja Shukra Arthava

Manas: S R T S R T

Agni:

Ama:

Assessment

Treatment Strategy

Treatment

Recommendations