Sebastian Pole
Traditional Herbal Medicine

HEALTH QUESTIONNAIRE

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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: ....

Title: (Mr, Mrs, Ms, Miss) ....

Forename(s): ....

Date: ....

Date of Birth: ....

Age: ....

Email: ....

Address: ....

Tel No: ....

....

Doctor & Surgery ....

Occupation: ....

Hobbies: ....

Marital status: ☐ Married ☐ Single ☐ Children (Ages)

....

Health record Past serious illnesses, medication & treatment:

Condition	Date	Treatment	Medication

Have you had hepatitis or any kidney problems? If yes when? ....

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

Weight: ....

Height: ....

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	
Siblings	

Current health Anything you would like to be addressed:

Condition	Symptoms	Duration

Current supplements

Name	Brand name	What is it for?	Strength	Dose	Frequency

Current medications

Name	Brand name	What is it for?	Strength	Dose	Frequency

Digestion Is your appetite (sensation of hunger):

☐ Erratic ☐ Sluggish ☐ Good ☐ Too good ☐ Balanced ☐ Do you get very thirsty?

Do you suffer from:

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

☐ Irritable bowel syndrome ☐ Abdominal pain ☐ Liver problems ☐ Gallstones ☐ Food intolerances: If yes what?

....

Which is your favourite flavour? ☐ Sweet ☐ Salty ☐ Sour ☐ Spicy ☐ Bitter

What do you have for the following meals?

Breakfast	
Lunch	
Supper	
Snacks	
Drinks	

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

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

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

Do you drink alcohol? ☐ Yes ☐ No If yes, what types? (Spirts, Beer) How often?

....Times/week

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

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

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

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

Elimination Bowels

Do you have a daily bowel movement? ☐ Yes ☐ No If yes please tick a box ☐ -1 ☐ 1 ☐ 2 ☐ 3 ☐ +4

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

Do you have haemorrhoids? ☐ Yes ☐ No

Do you have diarrhoea? ☐ Yes ☐ No

Do your stools:

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

Immunity Do you suffer from any of the following conditions?

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

☐ Psoriasis ☐ Hay fever ☐ Candida ☐ Migraine ☐ Irritable bowel ☐ Asthma

☐ Other ....

Do you have strong immunity? .... How many colds/flu do you get a year? ....

Urination Please tick boes that apply to you:

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

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

☐ Painful urination ☐ Frequent urination ☐ Blood in urine

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

☐ Decrease in flow ☐ Prostate enlargement ☐ Irregular flow

☐ Difficulty stopping or starting ☐ Inability to hold urine

Metabolic vitality Please tick boes that apply to you:

☐ Erratic energy ☐ Night sweats ☐ Frequent fevers

☐ Chronic fatigue ☐ Slow metabolism ☐ Chills

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

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

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

☐ Are you muzzy headed in the morning?

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

Mind and emotions

How do you feel about the following areas of your life? Please check appropriate boxes and make any additional comments if you would like to.

	Excellent	Good	Fair	Poor	Comments
Yourself	☐	☐	☐	☐	
Finances	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	
Family	☐	☐	☐	☐	
Life purpose	☐	☐	☐	☐	
Spouse / Partner	☐	☐	☐	☐	

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

Is there an excess of stress in your life? ☐ Yes ☐ No

If yes, what is causing you so much stress? ....

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

If Yes what are they? ....

Are you satisfied with your current living/working environment? ☐ Yes ☐ No

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

....

Are you a 'nervous type' person? ☐ Yes ☐ No

If yes, what things make you most nervous? ....

What feelings do you most often experience in your life?

☐ Joy ☐ Happiness ☐ Anger ☐ Sadness ☐ Fear ☐ Anxiety ☐ Worry ☐ Depression

Men's reproductive health Do you suffer from:

☐ Excess urination	☐ Low libido	☐ Excess libido
☐ Infertility	☐ Impotence	☐ Prostate enlargement

Women's reproductive health

Date of last period .... Cycle length .... How many days does your period last? ....

Do you suffer from:

☐ Pain When and please describe? ....

☐ Migraines at menstruation When?..

☐ Food cravings What?...

☐ Breast distension

☐ Clots

☐ Low libido

☐ Excess libido

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

☐ Do you suffer from PMS?

What happens?..

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

Type of contraception:

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

If yes, which one? ....

Do you use: ☐ IUD ☐ Condoms ☐ Diaphragm For how long? ....

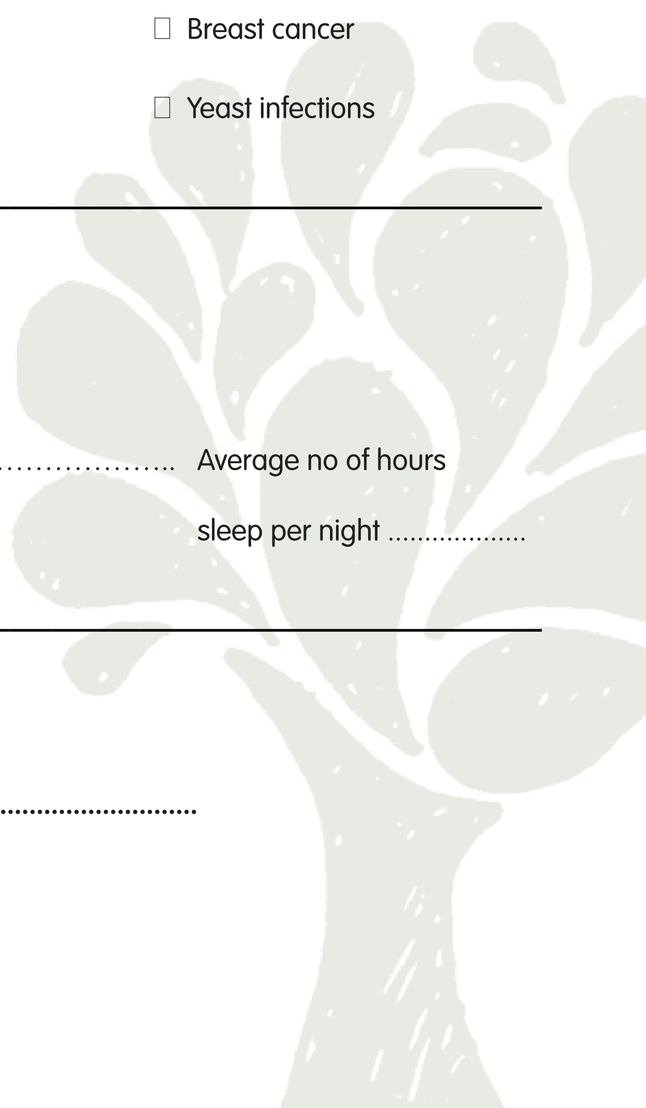
Are you pregnant? ☐ Yes ☐ No Are you trying to conceive? ☐ Yes ☐ No

How many pregnancies? .... Do you have children? ☐ Yes ☐ No

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

Have you had / do you have?

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



Sleep

Do you get to sleep easy? ☐ Yes ☐ No

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

Do you wake up in the night? ☐ Yes ☐ No What time? ……………….. Average no of hours sleep per night ....

Heart

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

Do you have palpitations? ☐ Yes ☐ No When? ....

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

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

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

Do you suffer from:

☐ Chest/heart pain	☐ Fainting	☐ Irregular heart beat
☐ Cold hands or feet	☐ Ankle swelling	☐ Palpations
☐ Easy bruising	☐ Varicose veins	☐ Blood clots

Skin and Hair Do you suffer from:

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

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

....

....

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

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

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

....

....

Respiration

Have you ever had breathing difficulties? ☐ Yes ☐ No

Do you wheeze? ☐ Yes ☐ No Cause? ……………..

Do you cough mucus? ☐ Yes ☐ No When and colour ....

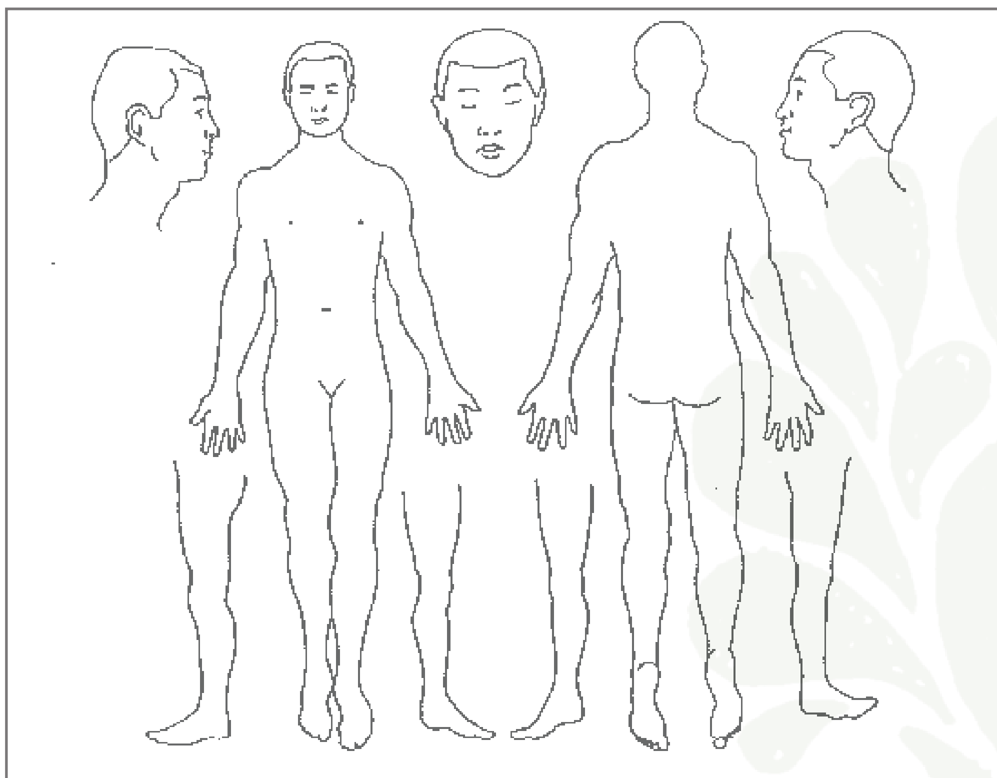
Do you regularly have a blocked nose? ☐ Yes ☐ No

Do you / have you smoked? ☐ Yes ☐ No

Pain

Do you have any pain(s)? ☐ Yes ☐ No

Please indicate painful or distressed areas below:



Area / Description of symptoms	Pain level: Low 0 - 10 High	Frequency

Musculoskeletal Please tick boxs that apply to you:

☐ Neck pain	☐ General muscle pain	☐ Muscle weakness
☐ Shoulder pain	☐ General stiffness	☐ Broken bones
☐ Joint pain	☐ Back pain	☐ Reduced movement

Eyes

Colour:	☐ Brown	☐ Light OR	☐ Dark
	☐ Blue	☐ Green	
Sclera:	☐ Yellow	☐ Red	☐ White

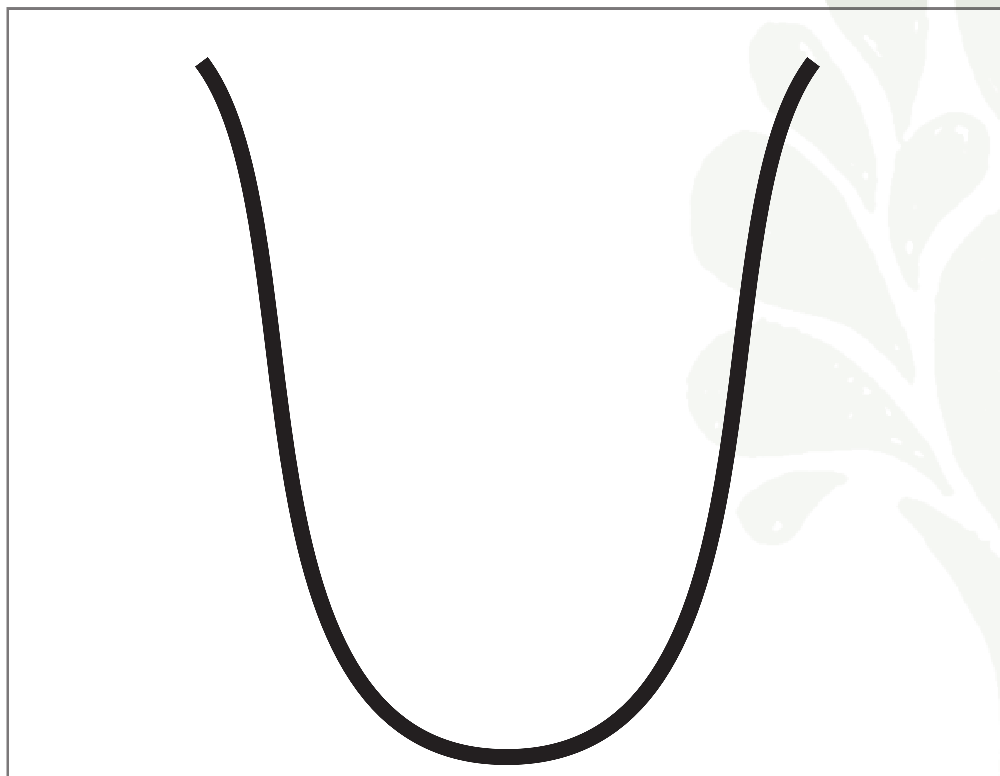
Pulse

Rate: .... Depth: .... Quality: .... Skin Feeling: ....

Tongue

Colour : .... Shape: .... Coating: .... Markings: ....

Tongue diagram:



For diagnosis only

Vikriti: V P K Prakriti: V P K

Dhatu: Rasa Rakta Mamsa Meda Asthi Majja Shukra Arthava

Manas S R T S R T

LHS: Ht/SI Liv/Gb Bl/Si

RHS: Lu Sp/St Kid/LI

YIN/ YANG FULL/ EMPTY HOT/ COLD INTERIOR/ EXTERIOR DAMP/DRY Qi Blood Fluids

Vikriti: V P K Prakriti: V P K

Dhatu:

Agni:

Koshta:

Ama:

Diagnosis: TP:

Prescription Formula:

Disease:

Dosha:

Dhatu:

Agni:

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