Mary R. Hunter, RN, BSN, LMT
Clinical Herbalist
Certified Nutritionist

Responsibility for Payment

1. Fees	Office Visit	$1.00/minute
	First visit usually 90 minutes	$90.00

2. The client is responsible for payment at time of service. We do not accept insurance. Itemized bills are available upon request for you to submit to your insurance company for reimbursement. I take cash, check or credit cards.

3. CANCELLATION POLICY: Cancellations must be made during clinic office hours at least one day prior to the appointment unless inclement weather or other emergencies arise. Otherwise you will be charged for the time booked.

I AGREE TO THE ABOVE CONDITIONS PRIOR TO TREATMENT.

Signature_____Date_____

Herbal Touch

Mary R. Hunter, RN, BSN, LMT
Clinical Herbalist
Certified Nutrititionist

P.O. Box 237 303-747-2602
Allenspark, CO 80510
www.healthybeattitudes.com e-mail: mary@healthybeattitudes.com

ADVISEMENT OF WESTERN MEDICAL EVALUATION

I understand the Mary R. Hunter is a Registered Nurse, Certified Clinical Herbalist, Certified Nutritionist and Licensed Massage Therapist. She is not a western medical doctor (MD, DO), and is neither authorized nor qualified to make western medical diagnosis, prognosis, evaluation or medical recommendations.

I am seeing Mary R. Hunter of my own choice, with the intention of receiving natural therapeutics for my health complaint. I understand that Clinical Herbalism, and/or therapeutic massage offer one aspect of my health care, and that a more in-depth overview may be served by an independent western medical (MD, DO) evaluation. I acknowledge the advice to consider independent medical (MD, DO) evaluation so as to be aware of conventional diagnosis, treatment, and prognosis.

Signature_____ Date_____

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Please fill out this questionnaire carefully and fax/email/send back to our office before your scheduled appointment. All information is kept confidential.

Date: _____
Name: _____
Phone: Home _____Work _____Mobile_____
Address: (Street, City State, Zip): _____
Occupation:_____
Date and Place of Birth:_____
Age: _____ Height_____ Weight_____
Relationship Status:
____Single and living alone
____Single and living with partner
____Married
_____Children?
How many? Age and Gender?
_____
If child, parents' names: _____
Family Physician/phone #: _____
In Case of Emergency Notify: _____
Referred By: _____

Primary Concerns:
Please include location of complaint, time of onset, cause (if known), factors that aggravate symptoms, and any other pertinent information. Rate each problem on a scale of 1 to 10 (minimal to severe) _____
_____
_____
_____

Secondary Concerns:
_____
_____
_____
What kind of treatments have you tried?_____
_____

Past Medical History (include date/age):_____
_____
_____
_____
_____

Childhood Illnesses: (coliic?)_____
Vaccinations: _____
Breast or Bottle fed:_____
Significant Illnesses: Cancer Diabetes Hypertension High Blood Pressure
Seizure Heart Disease Rheumatic Fever Thyroid Disease STD's
Other_____
_____
_____
Surgeries (please include date/age): _____
_____
_____
Significant Trauma/Life events (auto accidents, falls, illnesses, divorce, deaths, miscarriages, loss of job, etc):

Event	When
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Birth History (prolonged labor, forceps delivery, etc): _____
_____
Allergies: (medication, food, chemical, etc) _____
_____
Family Medical History: Diabetes Cancer High Blood Pressure Heart Disease
Stroke Seizures Asthma Allergies Other_____
_____
_____

Medications, Herbs, Supplements, Homeopathics: _____
_____
_____
_____
Use of antibiotics or oral contraceptives: (number of year/frequency):_____
_____

Occupation(s)_____
Occupational stress (chemical, physical, psychological, etc):_____
_____

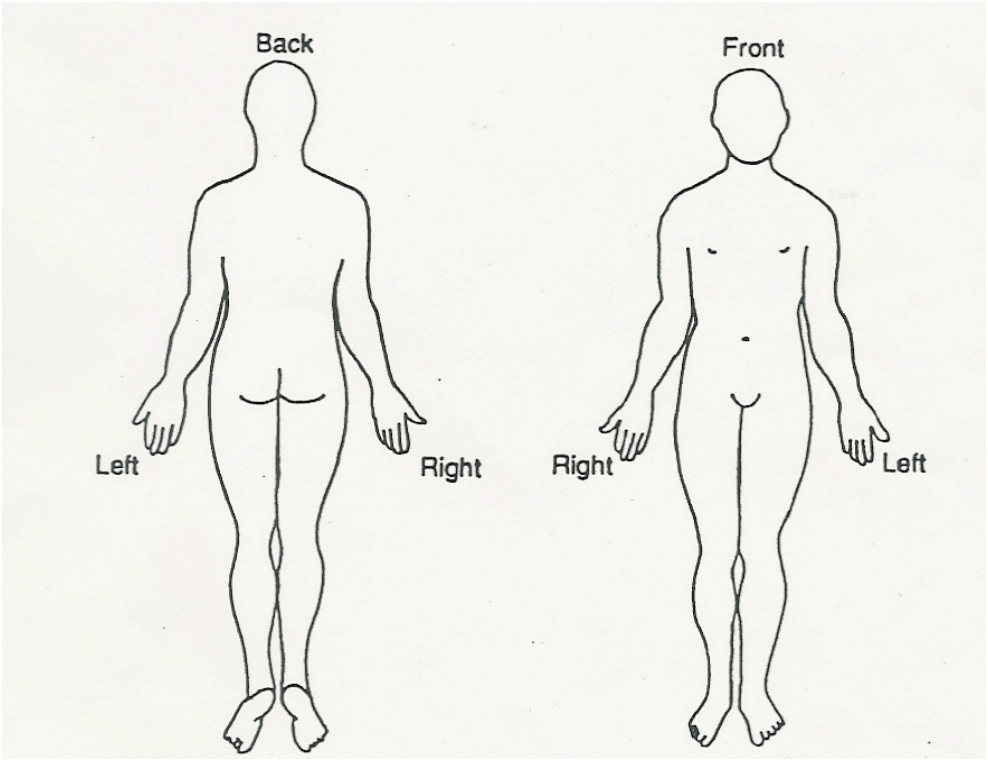
Sleep: How many hours do you get each night?_____Do you fall asleep easily?_____
Do you wake up during the night?_____Do you wake up refreshed?_____
Do you take anything to help you get to sleep?_____If so, what?_____

Diet: Have you been on a restricted diet?_____What kind?_____
_____
Please describe your average daily diet:
Breakfast Snack Lunch Snack Supper Snack
_____
_____
_____

What is your blood type? _____
How much water do you drink?_____How much coffee/caffeine?_____
How much soft drinks?_____How much/what type?_____
What is your favorite snack food(s)?_____How often?_____
Do you smoke?_____How much/what type?_____When did you quit?_____
Do you drink alcohol?_____How much/what type?_____When did you quit?____

Exercise: Type and # of times per week _____
_____

Indicate paiful or distressed areas
Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.
Ache-A Pins and Needles-P Burning-B Stabbing-S
Numbness-N Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling **at this time**.
1----------10
NO PAIN WORST PAIN IMAGINABLE

Please circle if you have had (in the last three months):

GENERAL

Poor appetite	Poor Sleeping	Fatigue
Fevers	Chills	Night sweats
Sweat easily	Tremors	Food cravings
Localized weakness	Poor balance	Change in appetite
Bleed or bruise easily	Weight loss	Weight gain

Sudden energy drops (what time of day?)

Please expand on the items you circled_____

_____

_____

SKIN AND HAIR

Rashes	Ulcerations	Hives
Itching	Eczema	Acne
Dandruff	Loss of hair	Recent moles

Change in hair or skin textureOther hair or skin problems

Please expand on the items you circled_____

_____

_____

HEAD, EYES, EARS, NOSE, AND THROAT

Dizziness	Concussions	Migraines
Glasses	Eye strain	Eye pain
Poor vision	Night blindness	Color Blindness
Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes
Sinus problems	Nose bleeds	Sore throats
Grinding teeth	Facial pain	Sore on lips/tongue
Headaches (when & where?)	Teeth problems	Silver dental fillings

Other head/neck problems

Please expand on the items you circled_____

_____

_____

CARDIOVASCULAR

High blood pressure	Low blood pressure	Chest pain
Irregular heartbeat	Dizziness	Fainting
Cold hands or feet	Swelling of hands	Swelling of feet
Blood clots	Phlebitis	Difficulty breathing

Other heart or blood vessel problems

Please expand on the items you circled_____

_____

_____

RESPIRATORY

Cough	Coughing blood	Asthma
Bronchitis	Pneumonia	Pain with deep breath
Difficulty breathing when lying down		Production of phlegm/color

Please expand on the items you circled_____
_____
_____

GASTROINTESTINAL

Nausea	Vomiting	Diarrhea
Constipation	Gas	Belching
Black stools	Blood in stools	Indigestion
Bad breath	Rectal pain	Hemorrhoids
Abdominal bloating	Food intolerances	Food cravings

Frequency of stools_____Describe stools_____
Please expand on the items you circled_____
_____
_____

GENITO-URINARY

Pain on urination	Frequent urination	Blood in urine
Urgency to urinate	Unable to hold urine	Kidney stones
Decrease in flow	Impotency	Sores on genitals

Other problems with genital or urinary system?
Do you wake up to urinate?_____How often?_____
Please expand on the items you circled_____
_____
_____

PREGNANCY AND GYNECOLOGY

Number of pregnancies_____	Number of births_____	Premature births_____
Miscarriages_____	Abortions_____	Age at first menses_____
# days between menses_____	Duration_____	First date of last menses_____
Heavy or light_____	Clots	Irregular periods
Painful periods	Vaginal discharge	Vaginal sores
Breast lumps	Changes in body/psyche prior to menstruation	

Do you practice birth control?_____What type and for how long?_____
Are you satisfied with this form of birth control?_____
Please expand on the items you circled_____
_____
_____

MUSCULOSKELETAL

Neck Pain	Muscle pains	Knee Pain
Back pain	Muscle weakness	Foot/ankle pains
Hand/wrist pain	Shoulder pain	Hip pain

Other joint or bone problems
Please expand on the items you circled_____
_____
_____

NEUROPSYCHOLOGICAL

Seizures	Dizziness	Loss of Balance
Areas of numbness	Lack of coordination	Poor memory
Concussion	Depression	Anxiety
Bad temper	Easily susceptible to stress	Pain (describe/rate1-10)

Have you ever been treated for emotional problems?_____
Have you ever considered or attempted suicide?_____
Other neurological or psychological problems?_____
Please expand on the items you circled_____
_____
_____

EMOTIONAL

Circle the words that most closely describe your life to date:

happy	interesting	dull	serene	hard	joyous
rebellious	slow	dissatisfying	restrictive	sweet	depressing
Murphy's Law	tumuluous	struggle	challenging	reckless	abusive
free	adventurous	julcy	painful	light	thrilling
uncomfortable	boring	full	tasteless	stressful	confusing
fulfilling	fast	creative	pioneering	angry	healthy
crisis to crisis	sad	roller coaster			

SOCIAL

What are your support systems?_____
Describe how you feel about the future?_____
What is your biggest fear?_____
Please describe any use of drugs for recreational purposes_____
What do you do for fun? List 5-10 favorite activities and how often you do them_____
_____
_____

SPIRITUAL

Describe yow you nurture your spiritual self_____
_____
_____

COMMENTS

_____
_____

Thank you for taking time to complete this questionnaire. I look forward to discussing with you soon!