TEA CELL

This form provides both herbalist and client with pertinent information regarding your health information. According to the Health Insurance Portability and Accountability(HIPPA) Laws Act of 1996, you as a client are protected and have the right to disclose what you want. This information is confidential and private. Please sign the attached waiver and privacy statement.

Name

Address

Street No. Street (apt.,suite)

City State

Zip

Contact Information

Phone

( ) ( )

Home/Cell Work

Email:

What is the best way to contact you? Home/Cell ◉ Email ◯

Primary Holistic Insurance Company (Please leave blank)

Occupation(s)

Gender Age

Male_____ Female_____ _____Yrs. _____Mos.

Height_____Feet _____Inches

Weight_____pounds_____kg

Relationship Status: Married_____ Single_____
Other_____

Are you currently breastfeeding or pregnant? Yes_____ No_____

Are you Intending to conceive? Yes _____ No _____

Do you have regular Breast(s) check ups?

Last Menstrual cycle? _____/_____/_____

_____

REASON FOR REQUEST

PRIMARY COMPLAINT

SECONDARY COMPLAINT

Region of Pain?_____

How long have you had the pain?_____

Onset of Pain?_____

PAST MEDICAL HISTORY

List of Allergies (medications and foods)

List of Past/ Upcoming Surgeries

List of Medications

Abnormal Weight: Loss_____lbs. Gain_____lbs.

Leg Pain? If so, Is it lower legs?

Do you have a history of blood clots in legs?

History of Smoking? If so, How Long?_____
Are you currently smoking?

Do you have any infections?

History of Venereal Disease?

Bowel Movements?

Are you having Shortness of Breath?

Do you have Asthma? If so, do you take an inhaler(brand)?
_____

Do you have urinary incontinence?
Liver Disease? If so, which disease?

History of Gallstones?

History of Kidney Stones?

Do you consume caffeine? If so how much?_____

Do you consume Alcohol?

Are you taking any drugs, habitual or recreational drugs? Please explain.

History of Birth Complications? If so, Explain

Family History of High Blood Pressure, Diabetes, Cancer? If so, Please explain. Explain Treatments.

Explain your current diet?

Do you watch television?
How often? _____
How long? _____
What genre of show/movies? _____

Are you active on your computer/phone?

How often do you exercise?

Are you willing to keep a daily food log?

Are you willing to keep a daily exercise log?

Eating Experiences

Do you get bloated when you eat?

Do you have satiety?

Gastroesophageal Reflux Disease (GERD)?

Stomach ulcers?

Have you ever had a Stroke?

Have you ever had a heart attack(MI)?

Are you currently experiencing chest pain?

If so, describe the feeling of your chest pain?
Location of Pain

Do you get fatigued? If so, Which stage: Relaxing or Exertion

Rate your stress levels 10 being highly Stressed?_____

What may be the cause of your Stress?

How many hours of sleep do you require?_____Hours

How many hours of sleep are you actually getting?_____Hours

Describe your sleeping experiences? Do you use devices to assist you when sleeping?

Check the following related symptom(s):

Symptoms	Y	N
Stress		
Headaches		
Hearing Impaired		
Migranes		
Dizziness		
Fainting		
Blurry Vision		
Tingling (hands,feet)		
Pins/Needles		
Loss of Feeling		
Joint Pain		
Arthritis		
Gout		
Bone Fractures		
Abnormal Balance		
Edema		
Weak Muscles		

History of Thyroid Disease? If so, What kind?

Check the symptom(s) related to Thyroid Disease:

Symptoms	Y	N
Unexpected Weight		
Abnormal Heartbeat		
Perspiration		
Irritability		
Excessive hunger		
Fatigue		
Palpitations		
Restless		
Mood Swings		
Nervousness		
Panic Attack		
Exophthalmos		
Sleepless/Insomnia		
Hair Loss		
Muscle Weakness		
Tremors		
Diarrhea		
Constipation		
Change in Temperture		
Hoarness		
Goiter		

Enlarged Thyroid		
Graves Disease		

Select the related symptom(s):

Symptoms	Y	N
Halitosis		
Menopause		
PMS		
Depression		
Heartburn		
Prostate Enlarged		
Abnormal Reproductive Cycle		
Asthma		
Bronchitis		
Bone Marrow		
Vomitting		
Hiccups		
Lack of Sleep		
Cramps		
Change in Vision		
Ovulation Complications		
Blood Clots (Lungs/Legs)		
Muscle Weakness		
Tenderness of Genitals		
Bone Weakness		

Nervousness		
Ulcers		
Abdominal Pain		
Impotency		
Lung Disease		
Pnemonia		
Indigestion		

Do you have Heart Disease? Explain.

Select the related symptom(s) to heart disease:

Symptoms	Y	N
Cornary Disease (CAD)		
Chest Pain		
High Blood Pressure		
Dizziness		
Cardiac Arrest		
Loss of Consciousness		
Arrthmia		
Heart Flutter		
Fainting		
Congestive Heart Failure (CHF)		
Shortness of Breath		

Fatigue		
Swollen Legs		
Rapid heart beat		
Stroke		
Paralysis		
Paralysis Right(R)		
Paralysis Left(L)		
Numbness (face,arm,legs)		
Congenital Heart Disease		
Swelling body		
Peripheral Artery Disease		
Abnormal Heart rhythm		
Family History		

Do you have any skin diseases? Explain.

Check related symptom(s) to Skin Disease:

Symptoms	Y	N
Temperature		
Cold		
Hot		
Rashes		

Eczema		
Rosacea		
Dandruff		
Acne		
Leakage		
Skin Discoloration		
Itchy Skin		
Bruises		

Other_____

Do you have hair issues? Explain.

Blood Type:

Do you have any Blood related diseases? If so, What kind?

Check the related symptom(s) to Blood disease:

Symptoms	Y	N
Abnormal Exhaustion		
Light-Headeness		
Memory		
Paleness (skin)		
Low Red Blood Cell count		

Intestinal Bleeding		

Any known Immune Disease? Explain

Checked related symptom(s) to Immune Disease:

Symptoms	Y	N
Cold Hands		
Restroom Issues		
Dry Eyes		
Fevers		
Joint Pain		
Low White Blood Cell Count		
Abnormal Lymph Nodes		
White Patches		
Yellow (Skin/Eyes)		
Infections		

Do you have any known Liver Disease? Explain.

Check related symptom(s) to Liver Disease:

Symptoms	Y	N
Nausea		
Dark Stool		
Dark Urine		
Abdominal Pain		
Swelling (legs,ankles)		
Chronic Fatigue		

Do you have a history of Cancer? If so, What kind?

Chemotherapy Year and Date:

_____/_____/_____

Type of Treatment	Y	N
Infusion		
Oral		

Radiation Treatment Year and Date:

_____/_____/_____

Describe your daily emotion(s).

Answer with Certified Herbalist

Do you have any other health issues you would like to discuss?

Any other problems you have that you feel will be valuable to help us work together to guide you into the right direction of your health?

Waiver of Liability

I understand It is my right to pursue various health practices and consult whom I wish to achieve my goals for better health. I understand that due to the Health Insurance Portability and Accountability Act of 1996, my medical information will maintain its confidentiality and privacy with Herbalist. I also understand that I, _____ am working with a consultant who makes no claims of being a health practitioner; This decision is solely at my will.

I understand no medical diagnosis, or medicine prescriptions will be given. I understand that **__Kevin D. Griffin C.H. ____**is an Herbalist and that he is not a Medical Physician (M.D.)(D.O.). I also understand that only a Medical Physician can diagnose and prescribe treatment. The suggestions given are **ONLY** suggestions and I must take responsibility for further educating and making myself aware of my body's health ailments and receiving proper medical care. I also understand that this is not a medical appointment and only a Medical Physician can provide treatment of injuries and/or illnesses.

___**Kevin D. Griffin C.H.**___ and other Certified Herbalists listed under the practice of Tea Cell, LLC accept no responsibility for my actions upon leaving his store/office, financial or otherwise for the outcome of herbal treatment recommended by the above-mentioned consultant, Herbalist(s). I also understand that **Tea Cell, LLC** accepts no responsibility for the effects that may occur from advice.

_____
Client's Signature

_____/_____/_____
Date

_____
Certified Herbalist Signature month day year

Tea Cell, LLC maintains your privacy and confidentiality being protected are crucial for a successful working relationship. We intend to fully honor our relationship to you and your privacy to the fullest. Occasionally I consult with other herbalist on a case by case basis and this is done only with your approval and written permission

_____

Signature

_____/_____/_____

Date

Submit

Submit

Reset

Please save a completed and signed copy of Intake form

Send a copy to:

tcells@teacells.com