Acute Illness Consultation Form

For health consultations, please fill out the following form and send it by email to: kelsey@myallforjesus.com When filling out the form, please be as specific and detailed as possible. The more information you share the easier it will be to offer you assistance. All information provided will be kept confidential and contact information will not be shared or passed on to other parties.

1) Contact Information

First Name: _____ Last Name: _____

Email: _____ Phone Number: _____

2) Client's Personal Information

Name of Client: _____ *(if different from above)*

Age: _____ Height: _____ Weight: _____ ☐ lbs/oz ☐ kg

Gender: Male ☐ Female ☐

Ethnic Group: _____ *(some health conditions are relative to race and family heritage)*

If you are submitting this form on behalf of another person, what is your relation to the client?

_____

Marital status? ☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed

3) Referral

Who referred you to us, or how did you hear about us?

_____

4) Current Health Concern

What is the nature of your health concern?

How long have you had this condition?

Do you have any medical diagnosis of your condition?
(if yes, please specify what the diagnosis is and who it was that gave the diagnosis)

Are you currently taking anything for this condition?
(medicines, pain killers, homeopathic treatments, nutritional supplements, etc.)

Have you ever had this condition before? If yes, was there any treatments you took that helped?

Please select any of the following health conditions that *currently* apply to you:

☐ Asthma / Allergies	☐ High Blood Pressure	☐ Heart Conditions
☐ Diabetes	☐ Low Blood Pressure	☐ Liver / Kidney Disorders
☐ Arthritis	☐ High Cholesterol	☐ Osteoporosis
☐ Depression	☐ Cysts / Fibroids	☐ Fibromyalgia
☐ AIDS / STDS	☐ Cancer	☐ Chronic Fatigue Syndrome

☐ Other:

Do you have any known allergies? *(medicine, foods, etc.)*

Please list all medications and supplements you take on a *regular* basis:
(including standard and traditional medicines, homeopathic treatments, herbal or nutritional supplements, etc.)

Please enter "yes", "no", or "in the past" regarding the use of each of the following:

– Coffee (if "yes" or "in the past" how many cups per day):
– Smoking (if "yes" or "in the past" how many packs per day):
– Soda pop (if "yes" or "in the past" how many ounces per day):
– Diet soda (if "yes" or "in the past" how many ounces per day):
– Steroids: – Antacids: – Laxatives:
– Alcohol (if "yes" or "in the past" how often / how much):
– Any alcohol addictions?
– Any drug addictions?

5) Signs & Symptoms

Please select all the following symptoms that *currently* apply to you:

Skin:

- ☐ Acne
- ☐ Rash
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Unusually dry
- ☐ Itchy
- ☐ Color change
- ☐ Unusual perspiration
- ☐ Blisters
- ☐ Boils
- ☐ Abscess
- ☐ Warts / moles
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Head:

- ☐ Headache
- ☐ Migraine
- ☐ Head injury
- ☐ Concussion
- ☐ Hair loss
- ☐ Hair thinning
- ☐ Unusually dry hair
- ☐ Unusually oily hair
- ☐ Hair breakage
- ☐ Dandruff
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Nose / Sinuses:

- ☐ Congestion
- ☐ Runny nose
- ☐ Nosebleeds
- ☐ Seasonal allergies
- ☐ Sinus pressure
- ☐ Loss of smell
- ☐ Frequent colds
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Eyes:

- ☐ Dry / watery
- ☐ Itchy
- ☐ Blurry vision
- ☐ Strain
- ☐ Dark under eyelids
- ☐ Double vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Stye
- ☐ Clear discharge
- ☐ Pussy Discharge
- ☐ Pink eye

☐ Red / bloodshot eyes ☐ Yellow eyes ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Ears:

☐ Earache ☐ Hearing loss ☐ Excess ear wax
☐ Discharge ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Mouth / Throat:

☐ Sore throat ☐ Hoarse voice ☐ Loss of voice
☐ Difficulty swallowing ☐ Canker sore ☐ Cold sore
☐ Swollen gums ☐ Gum disease ☐ Sensitive gums
☐ Sensitive teeth ☐ Toothache ☐ Dentures
☐ Loss of taste ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Neck:

☐ Stiffness ☐ Swollen glands ☐ Sore movement
☐ Tight muscles ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Respiratory:

☐ Persistent Cough ☐ Wet cough ☐ Dry cough
☐ Coughing phlegm ☐ Coughing blood ☐ Wheezing
☐ Painful breathing ☐ Asthma ☐ Chest pain
☐ Shortness of breath (with exertion) ☐ Shortness of breath (when sitting)
☐ Shortness of breath (when lying down) ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Cardiovascular:

☐ High blood pressure ☐ Chest pain ☐ Palpitations
☐ Uneven heartbeat ☐ Low blood pressure ☐ Murmurs
☐ Other:

If you checked any of the above symptoms, please give a brief description:

Gastro / Urinary:
☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Bloating ☐ Gas
☐ Indigestion ☐ Heartburn / acid reflux ☐ Change in appetite
☐ Ulcer ☐ Hemorrhoids ☐ Discharge / blood
☐ Gallstones ☐ Kidney stones ☐ Painful urination
☐ Painful bowl movements ☐ Blood in urine ☐ Blood in stools
☐ Upset stomach ☐ Rumble sounds in belly ☐ Urine color is dark brown
☐ Urine color is clear or pale yellow ☐ Urine color is dark yellow or orange
☐ Other:

If you checked any of the above symptoms, please give a brief description:

Arms / Legs:
☐ Swollen ankles ☐ Swollen wrists ☐ Varicose veins
☐ Other:

If you checked any of the above symptoms, please give a brief description:

Muscular:
☐ Weakness ☐ Stiffness ☐ Tremors
☐ Leg cramps ☐ Restless leg syndrome ☐ Arthritis
☐ Joint pain ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Nervous:
☐ Paralysis ☐ Numbness ☐ Tingling sensations
☐ Seizures ☐ Carpal tunnel ☐ Fainting

☐ Back pain that shoots down to the legs ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Male Health:

☐ Testicular pain ☐ Testicular swelling ☐ Hernia
☐ Discharge ☐ Prostate disease / symptoms ☐ AIDS / STD
☐ Decreased libido ☐ Impotency ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Female Health:

☐ Menstrual pain ☐ Heavy menstrual bleeding ☐ Menstrual cramps
☐ Non-menstrual cramps ☐ Irregular periods ☐ Dry vagina
☐ Unusual vaginal discharge ☐ Vaginal thrush ☐ Candida
☐ Vaginal burning or itching ☐ Sores in vagina ☐ Decreased libido
☐ Pain with intercourse ☐ AIDS / STD ☐ Painful or sore breasts
☐ Mastitis ☐ Pregnant ☐ Infertility
☐ Menopausal ☐ Post-menopausal ☐ Hot-flashes
☐ Cysts / polyps ☐ Other:

If you checked any of the above symptoms, please give a brief description:

6) Health History

In general, how has your health been in the past?

Have you ever had any operations or surgeries performed? If yes, please specify.

Please list any vaccinations / immunizations you have had:

Are there any health conditions that run in your family?

Please select any of the following health conditions you have had in the past:

☐ Chicken Pox	☐ Hepatitis / Jaundice	☐ Gall/Kidney Stones	☐ Anemia
☐ Shingles	☐ Malaria	☐ Colitis	☐ Panic Attacks
☐ Measles	☐ Typhoid	☐ Ulcers	☐ Mental Illness
☐ Cysts / Fibroids	☐ TB	☐ Pneumonia	☐ Depression
☐ Cancer	☐ Heart Problems	Other:	

Are any of the above conditions still affecting you today? If yes, please explain.

7) Final Remarks

The space below is provided for you to include any further information or comments that you feel may be relevant to your current health condition, or helpful in understanding your health history:

8) Terms and Conditions

Please type your name in the space provided below and check the box if you agree to the given statement.

☐ I, ____________, understand that in submitting this form I am making an inquiry and seeking consultation in regards to the health condition(s) mentioned above. I understand that the recipient of this consultation form, Kelsey Weber, is not a medical doctor, but is a naturopath with a diploma in herbal medicine. I understand that only licensed doctors and practitioners can give a diagnosis or treatment to any medical conditions and that this is simply a consultation and will not result in a diagnosis or prescribed treatment.

I furthermore understand that I am taking full responsibility for my health. Any action I take as a result of this, or any following consultations, is done on my own accord. Kelsey Weber is in no way responsible for the outcome of any treatments I choose to take. I will in no ways hold others liable for the action I take in regards to my health.

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Please submit completed form by email to: kelsey@myallforjesus.com