Dale Bellisfield, RN, AHG

Dietary Recall

Patient Name _____

Please provide a detailed diet diary, complete with snacks and beverages, from a consecutive 5 day period to include a weekend. It is essential that this be completed and either mailed with Herbal History Questionnaire or brought in for initial visit.

Thank you.

Day 1

Morning _____
snacks _____
lunch _____
dinner _____
snacks _____
additional _____

Day 2

morning _____
snacks _____
lunch _____
dinner _____
snacks _____
additional _____

Day 3

morning _____
snacks _____
lunch _____
dinner _____
snacks _____
additional _____

Day 4

morning _____
snacks _____
lunch _____
dinner _____
snacks _____
additional _____

Day 5

morning _____
snacks _____
lunch _____
dinner _____
snacks _____
additional _____

Any additional comments: _____

Dale Bellisfield, RN, AHG

Herbal History Questionnaire

Please fill out the following questionnaire and Food Diary to help me provide a medical evaluation and bring it with you at the time of your initial visit. Please bring any medical history, blood tests, etc., that you feel might be helpful. I would also like to see any supplements or medications that you are taking. I look forward to meeting you.

Name _____ Date: _____

Family Physician _____ Phone Number _____

Marital Status _____ Height _____ Weight _____ Age_____

List the main problem (s) you would like help with in descending order. For each problem, include how long you have had this problem; how it interferes in your daily activities, whether you have been diagnosed by a physician; and what kinds of treatments you have tried.

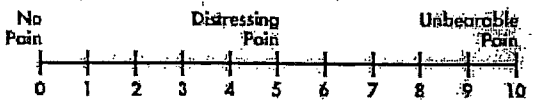
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Herbalist Notes

Allergies: _____
_____
_____

Pain Assessment:
Please complete the pain scale (if applicable).

0-10 Numeric Pain Distress Scale



☐ Dull ☐ Sharp
☐ Shooting ☐ Stabbing
☐ Burning
☐ Other_____
☐ Continuous
☐ Intermittent

Please indicate the location of your pain: _____
_____
_____
_____
_____
_____

Name_____

Herbalist Notes

Present Health Status:

I. General Health Status Excellent Fair Poor

II. Please check the following symptoms that apply.
Indicate as follows: X Experience symptoms sometimes
XX Experience symptoms often
XXX A major concern

Respiratory
____Asthma
____Bronchitis
____Difficulty breathing
____Congestion
____Cough ____Dry ____Productive
____Tuberculosis

Cardiovascular
____Blood Pressure
____Cholesterol
____LDL ____HDL
____Triglycerides
____Angina, chest pain
____Edema
____Poor Circulation -cold hands/feet
____Swelling ankles
____Swelling hands
____Previous Stroke or TIA
____Heart Murmur (MVP)

Muscles/Joints
____Aching muscles
____Backache ____ upper/lower
____ neck
____Broken bones
____Mobility restriction
____Arthritis
____Osteoporosis
____Weak teeth
____Weak ankles

Urinary/Kidney
____Urinary tract infections
____Excessive Urination
____Incontinence
____Water retention/Edema
____Burning urine
____Up at night to urinate
____Color or distinct odor
____Dark circles under eyes
____Puffy under eyes
____Kidney infections
____Prolapsed Bladder

Eyes
____Dry
____Itchy
____Runny
____Failing vision
____night only

Nose
____Sinus Congestion
____Sinus infection
____Sinus headache
____Colds & Flu...Frequency ___
____Post-Nasal drip

Ears
____Earaches/Infections
____Hearing loss
____Itchy ears
____Tinnitus, ringing in ears

Throat
____Tonsilitis
____Strep
____Swollen glands
____Swollen lymph nodes

Endocrine
Thyroid
____Hypo-sluggish metabolism
____Hyper-racing metabolism
Sugar imbalances
____hypoglycemia
____diabetes
Adrenals
____dark circles under eyes

Name_____

Immune system

-hyper (allegies)

____Hayfever
(pollens, grasses, ragweed)
____Molds, mildew, fungus
____Animal dander
____Food Intolerances
____Drugs

-hypo (depletion)

____Mononucleosis
____HIV-AIDS
____Cancer
____Chronic Fatigue Syndrome
____EBV (Epstein-Barr Virus)
____Fibromyalgia
____CMV (Cyto Meglia Virus)

Skin

____Acne
____Boils
____Bruises easily
____Dryness
____Itching
____Varicose Veins
____Cysts
____Hives
____Butt/upper back pimples
____Eczema
____Psoriasis

Autoimmune

____Lupus
____Scleroderma
____Chron's
____Interstitial Cystitis
____Rheumatoid arthritis

Immune general: Frequency of

____Colds
____Flu
____Ear Infections
____Throat Infections
____Bronchial Infections

Nervous System

Emotional Imbalances/Mood Disorders
____Addictive/compulsive behavior
____Anger (excess)
____Fear, projection (excess)
____Joy (excess)
____Nervous irritability
____Anxiety
____Anxiety attacks
____Nervous tension-muscles/headache
____Mood swings
____Seasonal Affective Disorder
____Restlessness
____Mild or Moderate Depression
____Chronic long-term Depression

Sleep

Hours from _____ to _____
Usually total ____hours
Number of times you wake up___
Number of times up to urinate___
How do you sleep?
Deep REM sleep with dreams?___
Trouble falling asleep, worry___
Trouble getting back to sleep___
Feel refreshed when awaken?___

____Crying spells
____Low self-esteem, worthlessness guilt
____Inability to concentrate, remember, make decisions
____Changes in these patterns ____thoughts of death/suicide
____sleep ____appetite ____sex

Herbalist Notes

Name_____

Female Reproductive:

Menstral History

____Age at first period
- ____heavy
- ____clots
- ____light
- ____painful cramps
- ____regular, every 28 days
- ____other
- ____bleeding between cycles
- ____absence of menses
- ____anemia?

PMS

____Anxiety
____Edema
____Breast tenderness

Abnormalities

____Ovarian Cysts
____Endometriosis
____Cervical Dysplasia
____Prolapsed uterus

Sexual Intercourse

____Low or lack of libido
____Painful intercourse
____Miscarriages
____Number of children & ages
____Birth control method now
____Birth control method -previously
____Trying to get pregnant?

Menopause

____Irregular periods
____Hot flashes
____Mood Swings
____Vaginal dryness
____Night Sweats
____Heart Palpitations

Breasts

____Fibrocystic breasts

Sexually Transmitted Diseases (STD'S) in you and/or your partner.

FEMALE

Vaginal Discharge?____Color?____

Infections

____Yeast/candida
____Trichomoniasis
____Gonorrhea
____Chlamydia
____Genital herpes
____Genital warts (HPV)

MALE

____yeast/candida
____Trichomoniasis
____Gonorrhea
____Chlamydia
____herpes, genital
____ (HPV) genital warts

Male Reproductive:

____Libido ___low ____high
____impotence
- ____psychological or physiological

____infertility
____premature ejaculation
____early aging
____hair loss
____low energy
____Benign swollen prostate (BPH)
____Prostatitis (BPH with infection)

Herbalist Notes

Name_____

Liver/Gallbladder

____Headaches behind eyes
____Headaches from temple along side to back of head
____Hepetitis, Type ____
____Liver damage?
____Swollen, tender liver
____Inflamed liver
____Pain on right side of abdomen
____Pain radiates to lower scapula
____Insufficient bile, cannot digest fats

Digestion

____Indigestion
____Hiatal hernia
____belching, stomach gas
____acid reflux, heartburn
____lactose intolerance
____gastritis
____ulcers
____burning feeling
____in stomach
____in esophagus

Elimination

____Stool usually moves
____ times daily
____other
____Constipation
____Frequency
____Diarrhea
____Recent travel to 3rd world country
____Abdominal bloating
____Irritable Bowel Syndrome
____Colitis
____Diverticulitis
____Hemorrhoids
____Anal fissures

Medications, remedies, you are taking NOW.

Prescription drugs _____
_____
_____
_____

Over the counter drugs _____
_____

Vitamins/Minerals/Supplements/Herbs_____
_____
_____
_____
_____

Medications you have taken in the last 5 years _____
_____
_____
_____

Family Health History:

Please place a letter for a relative if they've had the disease. M (mother), F (father), S (sister), B (brother), G'MA (grandmother), G'Pa (grandfather), A (aunt), U (uncle)

____Heart Disease
____Emphysema
____Asthma
____Skin Disease
____Kidney Disease
____Cancer
____Diabetes
____Thyroid Disease
____Liver Disease
____Liver Disease

Herbalist Notes

Name_____

Exercise:
List forms of exercise and how often you do it. _____
_____
_____
_____
_____

Habits:
_____Smoke, how many per day____
_____Drinks, how many per day or week ____
_____Coffee
_____ Tea
_____Soda
_____Alcohol _____ mixed drink _____ beer (s)

_____**Snacks**	Candy Bar
Chips	Donuts
Pretzels	Muffins
Gum	Pastry
Hard Candy	Ice Cream
Chocolate	Cake
Cookies	

Fast Food? What & how often?
_____

_____**Stress Reduction Techniques:**	_____T'Ai Chi
_____Yoga	_____Stretching
_____Meditation	_____Massage
_____Biofeedback	_____ Others?
_____Prayer	

Employment:
Occupation _____
How long in present position _____
Work hours _____
Days per week _____, Overtime _____How often _____
Stress Factors:
_____Repetitive motion
_____Computer fatigue
_____Deadlines
_____Boss
Injury potential?
Past jobs, if helpful info: _____
_____
_____

Herbalist Notes

Name_____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

X _____

Patient Signature

X _____

Date

_____

Clinical Herbalist Signature

_____

Date

Herbalist Notes

CLINICAL HERBALIST INFORMED CLIENT CONSENT

I, _____ voluntarily consent to be treated by Dale Bellisfield, RN, AHG. I understand that herbal therapy is administered in an attempt to improve bodily function, strengthen and increase health, and thus build resistance to stress and pathogens.

I acknowledge that, although rare, certain side effects may result from herbal therapy, which can include allergic rections. I accept the fact that no guarantee is made concerning the use and effects of herbal therapy, and I understand I may stop treatment at any time.

I understand the evaluation given me is not meant to replace western medical examination and diagnosis. I understand that Dale Bellisfield, RN, AHG does not diagnose diseases or claim to cure them.

I acknowledge that Dale Bellisfield, RN, AHG is not a medical doctor, and does not use or advise on the use of medically prescribed pharmaceuticals or medical treatment.

Herbal therapeutics are not meant to replace medical diagnosis or treatment. If symptoms are severe or persistent, I understand that I should consult with a medical doctor.

I certify that I have fully read and understand the above consent.

_____

Signature of Client or Guardian

_____

Signature of Practitioner

_____

Date

Dale Bellisfield, RN. Clinical Herbalist. 7 Ballard Place. Fair Lawn, NJ 07410

201.797.2583

FAX 201.797.4123

DALE BELLISFIELD, RN, AHG

Consent for the Release of Information

I hereby authorize Dale Bellisfield, RN at the Siegler Center For Integrative Medicine, 200 South Orange Avenue, Livingston, NJ 07039, 973-322-7007

To Obtain From:

Name/address/phone required:

_____

_____

_____

_____

My records from_____ to _____.

Include the following within the above dates:

___Initial Assessment ___Progress Notes ___Discharge Summary

___Laboratory Tests ___Office Notes ___History & Physical

___Other_____

I DO EXPRESSLY AND VOLUNTARILY AUTHORIZE THE DISCLOSURE OF THE SAID MEDICAL RECORDS TO THE PERSON(S) AND/OR ENTITIES AS STATED ABOVE. I UNDERSTAND THAT THIS CONSENT CAN BE REVOKED AT ANY TIME BY LETTER, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN, AND THAT THIS CONSENT WILL REMAIN IN EFFECT NO LONGER THAN THE TIME REASONABLY NECESSARY TO ACCOMPLISH THE PURPOSES FOR WHICH IT IS GIVEN.

_____ _____ _____

Patient Name Patient Signature Date

_____ _____ _____

Practitioner Name Practitioner Signature Date

Dale Bellisfield, RN. Clinical Herbalist. 7 Ballard Place. Fair Lawn, NJ 07410

201.797.2583

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Dale Bellisfield, RN, AHG

Clinical Herbalist Cancellation Policy

It is the policy of this office to charge a fee for missing an appointment or cancelling an appointment in less than one working day's notice. This policy is explained at the time of the first visit.

The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. And this also allows us to schedule other patients who need urgent visits into the newly available times.

Cancellations of convenience or last minute scheduling conflicts are your responsibility.

Acute health problems, environmental and family crises are exempt from this.

We remain available to discuss this policy in general, or any individual circumstances.

Thank you for your consideration.

Dale Bellisfield, RN, AHG

Patient

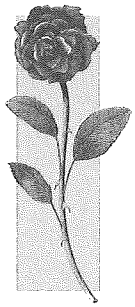
Date

Credit Card Number & Expiration Date

Dale Bellisfield, RN. Clinical Herbalist. 7 Ballard Place. Fair Lawn, NJ 07410

201.797.2583

FAX 201.797.4123



Herbal Consultation & Product Pricing

Initial Visit (@ 2 Hours)..... $350.00

Program Development Time (@ $75/hr)..... To Be Determined
Estimated after initial visit, payable in advance.

Follow-up visit (@ $150/hr)..... $75.00 – 150.00

Herbal Extracts ($12/oz.)..... $24.00 – 165.00/mo

Herbal Teas ($5/oz.)..... $ 5 .00 – 70.00/16 oz.

Supplements, Topical Products, Essential Oils..... As Marked

NJ RN License #26NO11483800
NY RN License #498300-1

December 2006

Dale Bellisfield, RN. Clinical Herbalist. 7 Ballard Place. Fair Lawn, NJ 07410

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