**Matthew Alfs, M.H., R.H. (A.H.G.)**

**Midwest Herbs & Healing Center**

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Roseville MN 55113

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**HERBAL CONSULTATION INTAKE FORM**

**Full Name**........................................................................................................…. **Sex**  M F............... **Date of Birth**.....................

**Home Address**................................................................... **City**................................................. **State**............ **Zip**............................

**Daytime Phone**...........................................**Evening Phone**.............................…………..**Other Phone**.............................................

**E-mail Address**.................................................................... **Fax**................................................... **Height & Weight**..........................

**Living Situation** (Circle applicable items): Partnered Not Partnered

**Emergency Contact Person and Phone** **Number**................................................................................................................................

**I Was** **Referred by**: ...................................................................................................................................................

**What Is (Are) Your Chief Complaint(s)?** .................................................................................................................................................................................................................. ..................................................................................................................................................................................................................

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**If the Problems Above Have been Treated Before, Please Explain What Was Done (including When, Where, and by Whom)**.....................................................................................................................................................................................................

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**Family History** (Family health conditions may be related to one’s own health conditions, via genetics, dietary and stress patterns, etc..)

Circle any occurrence of the following conditions in your family (inclusive of grandparents, parents, or siblings).

Heart disease Diabetes Arthritis Osteoporosis Alzheimer’s

Parkinson’s Mental Illness Thyroid condition Liver condition Kidney condition

**Your Own Health History:** Starting as a Child, Describe your Health *upUntil the Present Day*, excluding only the Main Complaint(s) addressed on the previous page. This Section is Very Important: *Be Sure* to Include *Any Medical Diagnoses* from the Recent or Distant Past (incl. even things like Depression, Hypothyroidism, Gastric Reflux), *Organ Removals* (Gallbladder, Spleen, etc.), *Health Incidents* (Kidney Stone passings, Accidents, etc.) or *Reasons* why you are, or have been, taking *any prescription or over-the counter (aspirin, ibuprofen, Prilosec, etc.) drugs* *not related to your “Chief Complaint(s)” listed on the previous page.* (In other words, if you are listing a drug below under “Please List All Medications You Currently Take” and the reason for it is *not* listed on the previous page under your “Main Complaints,” the Reason for Its Use Should *Go Here*, in the Present Section.) ................................................................................................................................................................................................................

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**Present Occupation**. Describe the Work that You Do, Your Hours, and the Effect that it Has on You..............................................

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**How Often Do You Exercise and What Form Does it Take?**.............................................................................................................

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**Please List All Medications that You Currently Take:**

Prescription..............................................................................................................................................................................................

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Natural (Herbs, Homeopathics, Vitamins, Minerals, Nutraceuticals,etc.)...............................................................................................

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**To the Best of Your Knowledge, Do You Have any Allergies/Sensitivities to any Drugs, Chemicals, or Foods? Please List, if so** .............................................................................................................................................................................................................

**Please List Any Exposures to Toxic Substances**, Naming Substance, Length of Exposure, and Date of Exposures

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**To the Best of your Knowledge or recollection, Please Provide the Figures for your Blood Pressure of Late?**

Averages from / to / . Check here if you have no idea: ..................

**If you can recollect with confidence, please list the figures for your latest lab readings for the following:**

Fasting Glucose (Blood Sugar).......... Triglycerides................. “Good” HDL Cholesterol ................

“Bad” (LDL) Cholesterol.................. Total Cholesterol........... TSH (Thyroid) ..................................

**Describe Your Stools by Noting the Following Two Pieces of Information Requested, as Follows:**

*Usual Frequency:* ........... times per (*Circle appropriate choice*:) Day *OR* Every Other Day  *OR* Week

*Do You Usually Have a Morning Stool?*  Yes No *Do you* *Have Chronic Hemorrhoids*? Yes No

*Typical Stool Consistency* (Circle appropriate:) Formed (like a banana) & of soft to medium consistency

Bit Loose/Gloppy (like a cowpie) Watery

Chunky & Hard Other..............

*Stool Buoyancy* (Circle appropriate answer:) Usually Sinks Usually Floats Don’t Know

*Do You Often (2+ times per week) Observe any of the Following Stool Colors/States?* (Circle any appropriate:)

Very Pale/Tan With Undigested Food Charcoal/Black Sticks to side of bowl when flushed

**Describe Your Urine by Circling the Appropriate Responses as Follows:**

*Usual color*: Clear Pale Yellow Medium Yellow Dark Yellow Brownish Pinkish tinge

*Usual consistency:* Translucent (clear) Cloudy Has some Mucous Has some Sediment.

List any urinary difficulties (difficulty starting, retention, pain upon urinating, incontinence, etc.).........................

**Please Describe Your Diet** (Circle One or More which Apply) *A*. Health Foods, but not Vegetarian per se

*B.* Lacto-Ovo Vegetarian  *C.* Vegan *D.* Heavy on Meat and Potatoes  *E.* Heavy on Sweets *F*. Heavy on Salty Snacks

**Which, if any, Foods Do You Crave**? *A.* Sweets *B.* Chocolate *C*. Butter/Cheese  *D*. Meat *E*. Salty Snacks

**How Many Servings per Week do You Have of the Following?**

Dairy Products White Flour Sweets (Ice Cream, Donuts, Candy, Cake, Pies, Pastries, etc.)

Hydrogenated Fats (Margarine, Microwave Popcorn, etc.) Fried Foods

Red Meat Orange Juice or Other Juices from Concentrates Dried Fruits

**Do you Smoke? What Form of Tobacco, and How Often**.........................................................

**Do you Drink any of the Following?**

*Coffee?* If yes, how often? *Tea?* If yes, how often?

*Juice* from Concentrates? If yes, how often? *Milk?* If yes, how often?

*Diet pop?* If yes, how often?  *Sugared Pop?* If yes, how often?

*Alcohol?* If yes, how often*? Hot Chocolate?* If yes, how often?

**How Is Your Sleep?**

Do You Usually Get to Sleep within 20 Minutes of Retiring ? Yes No

Do You Often (3x Week or more) Wake Up in the Middle of the Night? Yes No

If so, Is Urinary Urgency the Main Factor—or A Factor—in this Awakening? Yes No

If you Awaken during the Night, do you then experience any: Palpitations? Yes No Breathing Difficulties? Yes No

Panic Attacks? Yes No

If you Awaken during the Night, do you usually Get Back to Sleep fairly easily? Yes No

How Many Total Hours of Actual Sleep Do you Average? (Circle Appropriate Figure) 5 6 7 8 9

**If You Are a Man**, Do You Have Problems with any of the Following? (Circle any appropriate)

Lack of Sexual Desire Impotence Premature Ejaculation Infertility Prostate Issues

**If You Are a Woman**, Do You Have, or Recently Have Had, Problems with any of the Following? *(Circle any appropriate*:)

Lack of Sexual Desire Infertility Miscarriages

Vaginal Dryness Hot Flashes Night Sweats

Recurrent Cystitis/UTIs (Bladder or Urethral Infections) Hirsutism (Lip Hair)

Recurrent Vaginal Yeast Infections Other Kinds of Vaginal Discharges......................................

Fibrocystic Breasts Uterine Fibroid Tumors Ovarian Cysts

**If You Are a Woman and Are Still Menstruating, Please Supply the Following Information....**

How long does your Monthly Cycle Average? \_\_\_ days How Long Does Your Bleed Average? \_\_\_ days

Do You Experience Any Premenstrual/Menstrual Phenomena as Listed Below (Please Circle, if so, & please provide elaboration on line following)

Cramps (When do they Begin and End? .................................................................................. On Which Days Are They Most Intense?............)

clots (What Color & When in the Menses? ...............................................................................................................................................)

hesitant bleeding (Describe circumstances.....................................................) light bleeding ..................................

heavy bleedinG (Color Changes When During? .................................................................................... ) mID-CYCLE BLEEDING

breast tenderness or other water retention (where?) anxiety or irritability gloominess

HEADACHES (When do they begin/end w/relation to menses?] ..................................................................... food cravings (What? ..........)

**To the Best of Your Knowledge, Are You *Pregnant* at the Current Time**?.............

**Are You Breastfeeding at the Current Time?**................................................................................................

**Please Underline or Circle Any of the Following which Apply to You.** *(A Problem May Be Mentioned More than Once, in which case Keep Noting it as it appears*.)  **This section is *Very Important*—Please Be Patient and Do the Best Job that You Can. (Important: If Faxing this Form Back to Us, Please Circle in Pen & Do Not Use Highlighter or Pencil.)**

*EFAPattern APattern B1Pattern*

\* Frequent Urination \* Gingivitis \* Constipation

\* Excessive Thirst \* Insomnia \* Indigestion

\* Dry Skin \* Chronic Acne \* Nausea

\* Rough Skin on back of \* Rough Skin on back of \* Poor Coordination

Upper Arms (“Gooseflesh”) Upper Arms (“Gooseflesh”) \* Palpitations

\* Little Red Blemishes on \* Frequent Infections \* Muscle Shrinkage (unexplained)

Upper Arms &/or Thighs \* Unexplained Weight Loss \* Agitation

\* Crust in *Upper* quadrant of Ears \* Loss of Smell or Taste \* Autonomic Dysfunction

\* Brittle Nails \* Poor Night Vision \* Depression

\* Dandruff \* Dry, lackluster Hair \* Fatigue

\* Hair Loss (Alopecia) \* Irritability

\* Dry, Stiff Hair \* Nervousness

\* Gallstones \* Numb Limbs

\* Chronic Diarrhea \* Low Pain Threshold

\* Anemia \* Shortness of Breath

\* Frequent Urination \* Constant Carb. Cravings

\* Loss of Kidney Function \* Slow Heartbeat

\* Fatty Liver \* Enlarged Heart

\* Brittle Nails \* Congestive Heart Failure

\* Acne \* Poor Retention of Information

\* Eczema

\* Infertility

\* Burning Feet

\* Cognitive Impairment (Memory loss,

lack of Concentration or Focus, Confusion)

\* Depression

\* Frequent Infections

\* Menstrual Cramps

*B2Pattern B3Pattern B5Pattern*

\* Cataracts\* Indigestion\* Blood Pressure under 115/65

\* Gingivitis\* Gingivitis\* Nausea

\* Hair Loss (Alopecia) \* Cracks at Corners of Lips\* Hair Loss (Alopecia)

\* Cracks at Corners of Lips \* Moodiness \* Cracks at Corners of Lips

\* Dry & Fissured Lips \* Nervousness \* Premature Gray Hair

\* Chronic Sore Mouth \* Peripheral Neuropathy \* Muscle Spasms

\* Cognitive Impairment (Memory loss, \* Bad Breath \* Brittle Nails

lack of Concentration or Focus, Confusion) \* Elevated LDL & Triglycerides \* Depression

\* Depression \* Depression \* Faintness

\* Dizziness \* Gastritis \* Fatigue

\* Rough Skin on Back of Upper Arms \* Tender gums, mouth, or tongue \* “Midnight Awakenings”

\* Hypothyroidism \* Dizziness \* Chronic Headaches

\* Disordered Blood Sugar \* High Total or LDL cholesterol \* Poor coordination

\* Cracked Skin at the Fingernails \* Irritability

\* Crusted Skin around the Nose \* Nervousness

\* Blurred vision \* Peripheral Neuropathy

\* Low Red Blood Cells \* Chronic Eczema

\* Burning, Red, & Sore Eyes \* Frequent Upper-respiratory

\* Reoccurring Migraines Infections (Bronchitis, Sinusitis)

\* Tingling in Hands &/or Feet

\* Teeth Grinding

*B6Pattern B12Pattern Bio[H]Pattern*

\* Nausea\* Chronic Intestinal Gas \* Dry Skin

\* Hair Loss (Alopecia) \* Palpitations \* Disordered Blood Sugar

\* Cracks at Corners of Lips \* Canker Sores \* Chronic Skin Rashes

\* Cognitive Impairment (Memory Loss, \* Chronic Sore Mouth\* Fine, brittle Hair

Lack of Concentration or Focus, Confusion) \* Burning Feet \* Chronic Hair Loss

\* Difficulty Remembering Dreams \* Cognitive Impairment (Memory, \* Depression

\* Dizziness Concentration, Focus, Confusion) \* Sleepiness

\* Seizures (infants) \* Depression \* Muscle Pain

\* Cervical Dysplasia \* Dizziness \* Flaking/Peeling Nails

\* Atherosclerosis \* Moodiness/Irritability \* Chronic Yeast/Fungal issues

\* Elevated Homocysteine levels \* Cervical Dysplasia \* Fatigue

\* Irritability \* Fatigue \* Cradle Cap (in Kids)

\* Nervousness \* Elevated Homocysteine Levels \* Neuropathy

\* Peripheral Neuropathy (sensory) \* Chronic Headaches \* Nausea

\* Sleepiness/Fatigue \* Peripheral Neuropathy

\* Acne \* Loss of Sense of Position

\* Eczema of the Feet

\* Facial Oiliness, but with other Skin Dry \* Insomnia

\* Pitting Edema \* Soreness in the Limbs

\* Unexplained Weight Loss \* Tinnitus

\* Poor Wound Healing \* Difficult Speech

\* Premenstrual Water Retention \* Low White Blood Cells

\* Carpal Tunnel Syndrome \* Low Red Blood Cells

*Fol[M]Pattern Chol[Quasi B4]Pattern Inos[Quasi B8]Pattern*

\* Constipation \* Liver Dysfunction \* Constipation

\* Chronic Diarrhea \* Fatty Liver \* Eczema

\* Canker sores \* Total Cholesterol levels under 140 \* Total Cholesterol over 240

\* Cracks at Corners of Lips \* Gallstones \* Panic Attacks

\* Apathy \* Glaucoma \* Obsessive-Compulsive Disorder

\* Cognitive Impairment (Memory, \* Alzheimer’s Disease \* Hair Loss

Concentration, Focus, Confusion) \* Myasthenia Gravis \* Any Eye disorder

\* Depression \* Bipolar Depression \* Insomnia

\* Fatigue or Lethargy \* Memory Loss

\* Poor-quality Nails & Hair \* Nerve Twitches

\* Peripheral Neuropathy \* Unexplained Weight Gain

\* Restless Legs

\* Cervical Dysplasia

\* Elevated Homocysteine levels

\* Low Blood Platelets

\* Low White Blood Cells

*CPattern DPattern EPattern*

\* Bleeding Gums \* Irritability \* Premenstrual Breast Tenderness

\* Fatigue \* Chronic Diarrhea \* Peripheral Neuropathy

\* Irritability \* Insomnia \* Blood Clots

\* Blood Pressure under 115/65 \* Nearsightedness \* Angina

\* Malaise \* Chronic Sore Mouth \* Spontaneous Bleeding (Eyes/Nose)

\* Easy Bruising \* Nervousness \* Palpitations

\* Poor Wound Healing \* Osteoporosis \* Chronic Tendonitis or Bursitis

\* Anemia \* Soft Teeth \* Fibrocystic Breast Disease

\* Hair with Split Ends \* Abnormal Heartbeat \* Infertility

\* Loose Teeth \* [Kids:] Sweaty Scalp when Asleep \* Low Sex Drive

\* Frequent or Sustained Infections \* [Kids:] Scalp sensitive to Combing \* History of Miscarriages

\* Premature Aging or Hair being Pulled \* Frequent Infections

\* Male Infertility \* [Kids:] Bulging Forehead \* Wounds Scar heavily

*CaPattern CrPattern CuPattern*

\* High Blood Pressure \* High or Low Blood Sugar \* Chronic Diarrhea

\* Osteoporosis \* Joint Pain \* Irregular Heartbeat

\* Palpitations \* Anxiety \* Low White Blood Cells

\* Spasms \* Fatigue \* Muscle Pain (Myalgia)

\* Brittle Nails \* Total Cholesterol over 240 \* Nervousness

\* Agitation \* Sugar Cravings \* Emphysema

\* Hyperactivity \* Triglycerides over 125 \* Frequent Infections

\* Insomnia \* HDL (“Good cholesterol”) under 40 \* Hair Loss

\* Nervousness \* Often wake up with a Headache \* Anemia

\* Peripheral Neuropathy \* Osteoarthritis

\* Eczema \* Osteoporosis

\* Indigestion from Fatty Foods \* Wounds don’t Clot well

\* Menstrual Cramps

\* Lots of Dental Caries (Cavities)

\* Wounds Don’t Clot Well

*Io/HypoThyrPattern FePattern MgPattern*

\* Unexplained Weight Gain \* Constipation\* High Blood Pressure

\* Fatigue \* Palpitations upon exertion \* Vertigo (Head spinning)

\* Total Cholesterol over 240 \* Cracks at Corners of Lips\* Menstrual Cramps

\* LDL (“Bad cholesterol”) over 150 \* Brittle Nails \* Muscle Pain (Myalgia)

\* Dry Skin \* Depression \* Spasms (esp. lower eyelids)

\* Dry & Lifeless Hair \* Fatigue \* Disordered Blood Sugar

\* Slow speech/other speech problems \* Enlarged Spleen \* Osteoporosis

\* Depression \* Pale Skin \* Agitation

\* Sluggishness \* Muscular Weakness \* Irritability

\* Often Wake up with a Headache \* Dizziness \* Hyperactivity

\* Metallic Taste in the Mouth \* Insomnia

\* Losing or Missing outer 1/3 of Eyebrows *MnPattern* \* Behavioral Issues

\* Lots of Skin Tags \* Fragile Bones \* Nervousness

\* Brittle Nails \* Fatigue \* Peripheral Neuropathy

\* Feel Cold/Cold Intolerance \* Disordered Blood Sugar \* Kidney stones (recurrent)

\* Breathe shallowly  *\** Infertility\* Irregular Heartbeat

\* Cry easily  \* Rapid Heartbeat (tachycardia)

\* Intensely dislike being watched *MoPattern* \* Seizures

\* Weak-muscled \* Irritability \* Asthma

\* Frequent or chronic Acne \* Sulfite sensitivity \* Tremor

\* Chronic Itching \* Chemical Sensitivities \* Edema

\* Poor Vision \* Lots of Dental Caries (Cavities) \* Chocolate cravings premenstrually

\* Monthly Menstrual Cycle under 28 days \* Rapid Heartbeat \* Muscular Tightness

\* Menses Prolonged, Heavy, & Painful

\* Bruise Easily

\* Slow Metabolism

\* Sluggish Bowel

\* Hoarse Voice

\* Swollen Eyelids

\* Musculoskeletal Aches

*KPattern SePattern NaPattern*

\* Constipation \* Cardiomyopathy\* Chronic Intestinal Gas

\* Irregular Heartbeat \* Anemia (hemolytic) \* Slow Heartbeat

\* Slow Heartbeat \* Hypertension \* Nausea

\* Muscular Weakness & Fatigue \* Muscle Pain (Myalgia) \* Spasms

\* Nervousness \* Chronically Inflamed Muscles \* Depression

\* Insomnia \* Infertility (if a Male) \* Moodiness

\* Shortness of Breath \* Total Cholesterol over 240 \* Lethargy

\* Acne \* Frequent Infections \* Fatigue

\* Carb cravings \* Chronic Immune Dysfunction \* Seizures

\* Edema \* Low Semen-replenishing potential \* Chronic Headaches

\* Thirst \* Chemical Sensitivities \* Unexplained Weight Loss

\* Total Cholesterol over 240 \* Cataracts \* Dehydration

*DisruptedIntestinalFloraPattern ZnPattern HypoPrPattern*

\* Antibiotic Use for more than 2 Weeks \* Hair Loss (Alopecia) \* Hair Loss (Alopecia)

\* Nagging Itch in Nose or Ears\* Brittle Nails \* Slow Heartbeat

\* Periodic Canker Sores\* Apathy\* Cracks at Corners of Lips

\* See Floaters\* Stunted Growth\* Fatty Liver

\* Periodic Yeast Infections\* Fatigue/Lethargy \* Irritability

\* Skin-Crawling Sensations \* Irritability \* Pitting Edema

\* Nail Fungus \* White-dotted Nails \* Poor Wound Healing

\* Tinea or Ringworm \* Impotence

\* Loss of Sense of Smell or Taste

\* Infertility (if a Male)

\* Low Libido/Low Testosterone levels

\* Acne

\* Eczema on Hands, Feet, or Genitals

\* Total Cholesterol over 240

\* Frequent Infections

\* Poor Wound Healing

\* Disordered Blood Sugar

*HypoAdr/Glycc Pattern HyperAdr/Glyc Pattern HypoMelatPattern*

\* Blood Pressure *under* 110 over 65 \* Trunkal Fat \* Cold Hands

\* Dizziness when arising quickly \* Forgetfulness \* Insomnia

from a prone or crouched position \* Depression \* Premature Aging

\* Light Sensitivity \* Insomnia \* Multiple Sclerosis

\* Salt Cravings (& feel *better* when eat it) \* Elevated Triglycerides (150+) \* Warts

\* Chronic Fatigue \* Low Sex drive \* Poor Immune response

\* Chronic Upper-Respiratory complaints \* Frequent Colds/Flu \* Acidic salivary pH

\* Stubborn Allergies \* Slow Wound healing

\* Inability to Make Decisions

\* Alcohol Intolerance/Sensitivity

\* Excessive Perspiration & Urination

\* Problems in the Hips, low Back, & Knees

*HyprThyrPattern HypoProgPattern HyprProgPattern*

\* Heat Intolerance \* Low Sex drive \* Depression

\* Nervousness \* Bone loss \* Sleepiness

\* Moist Palms & Perspire a lot in general \* Sleep disturbances \* Late Menses (32-35 days)

\* Feel “Burned out” \* Urinary urgency \* Scanty Menstrual flow

\* A constantly Fast Heartbeat \* Little urine when urinating

\* Poor balance when standing on one Leg \* Early Menses (under 28 days),

\* Loose & Frequent Stools with crampy & long flow

\* Little or no Menses

*HyprEstrPattern HypoEstrPattern HypoTestPattern HyprTestPattern*

\* Low Sex drive \* Hot Flashes \* Low Sex drive \* Aggression

\* Nervousness \* Night Sweats \* Thinning Skin \* Acne

\* Ovarian Cysts \* Vaginal Dryness \* Muscle-mass Loss \* Irritability

\* Elevated Triglycerides (150+) \* Late Menses w/short Bleed \* Loss of Bone Density \* (Women:) Scalp Hair loss

\* Fibrous Breasts \* Loss of Bone Density \* (Men:) Decreased Erections \* (Women:) Polycystic Ovaries

\* Headaches \* (Women:) Hair Growth on Lip

\* Weight Gain in Hips *HypoDHEAPattern*  \* (Women:) Straggling Chin Hairs

\* Premenstrual Breast tenderness \* Low Sex drive \* (Women:) Weight Gain

\* 21-27-day Menstrual Cycles \* Premature Aging \* (Women:) Infertility

\* Heavy & Long Menstrual Bleeds \* Fatigue

\* Loss of Hair on lower legs, pubic region, or armpits

*DigWkness Pattern Fat-Dig Wkness Pattern HyprDigPattern*

\* Intestinal Gas after Eating \* Nausea after Fatty Meals \* Strong Appetite

\* Belching after Eating \* Digestive Upset after Fatty Meals \* Frequent Heartburn

\* Indigestion \* Sour Belching after Eating Fats \* Thirst w/Desire for Cold Drinks

\* Rectal Itching \* Stools Stick to Toilet Bowl \* Bottled-up Anger

\* Nausea/Bloat after Eating \* Clay-colored Stools \* Constipation

\* Undigested Food in Stools \* Frontal Headaches after Fatty Meals \* Burning Pain in Stomach or Esophagus

*CardWkness Pattern BldWkness Pattern LvCong Pattern*

\* Palpitations \* Dry Eyes \* Constipation with Hard, Chunky Stools

\* Cold Hands or Feet \* Poor Night Vision \* Depression, worse in the A.M.

\* Insomnia w/Dream-disturbed Sleep \* Blurred Vision \* Discomfort in Ride Side under Ribs

\* Lassitude (Low Energy) \* Brittle & Pale Nails \* Frequent Sighing

\* Oppressive Feeling in Chest \* Scanty & Light-colored Menses \* Feeling of a Lump/Object in the Throat

\* Bouts of Dizziness \* Dry Skin \* Cysts/Lumps in the Breasts or Groin

\* Ankle Puffiness or Swelling \* Strict Vegetarian Diet \* Facial Skin Warm, but Limbs Cold

\* Pale Face and Body Skin \* Feeling as if in a “Rut” in Life

\* Hypertension

*HyprLv/Fire/Yellow-bile Pattern BldWknPattern Earth/Black-bile Pattern*

\* Red or Irritated Eyes when Angry \* Dripping after Urination \* Depression

\* Bitter taste in the Mouth/Acid Reflux \* Frequent, Clear, Copious Urine \* Stubborn Constipation w/Dark Stools

\* Tinnitus (Ringing in the Ears) \* Sneeze or Cough Incontinence \* Stiff Joints

\* Irritability or Bottled-up Anger \* Frequent Nighttime Trips to Urinate \* Cancer

\* Reoccurring, Burning Sores (Lips, Anus, Mouth) \* Chronic Intestinal Gas (Flatulence)

\* Burning Pain Under the Ribs on *KidWkn Pattern* \* Bipolar Disorder

the Right Side of the Body \* Low-back Pain \* Schizophrenia

\* Nightmares \* Puffiness or Swelling in Ankles \* Enlarged Spleen

\* Hepatitis or Jaundice (circle which) \* Puffy Lower Eyelids \* Kidney Failure

\* Expansive Migraine Headaches \* Puffy Bags under the Eyes \* Insomnia

\* Dark or Burning Urine (circle which) \* Low Energy Levels \* Frequent Yawning

\* Strong Thirst for Cool Drinks \* Frequent Urination \* Very Dark Menses

*Air/HyprBld Pattern Water/Phlegmatic Pattern AyuVatPattern*

\* Hemorrhoids or Varicose Leg Veins \* Drowsiness or Lethargy \* Insomnia

\* Expansive Headaches with Red Face or Ears \* Cysts, Skin Tags, or Growths \* Chronic Flatulence/Irritable Colon

\* Ravenous Appetite \* Infertility or Impotence \* Dry Mouth

\* Reddish Nails \* Weight Gain \* Nerve Pains (incl. Sciatica)

\* Sweat profusely \* Lots of Mucous \* Migrating Pains

\* Hypertension \* Weeping Eczema \* Low Back Ache

\* Lethargy \* Water Retention (Edema) \* Frequent Yawning or Hiccups

\* Cracked Nails \* Chronic or Reoccurring Nausea \* Thirsty a Lot

\* Heavy Menses with Bright-Red Blood \* Chronic Itching \* Joint Pain

\* Reddish, Warm Skin (in Caucasians) \* Fasting Blood Sugar (Glucose) Above 99

\* History of Embolism or Aneurism \* Whitish Secretions (Vagina, Nose, Ears)

\* Highly Attractive to Ticks, Mosquitoes, \* Chronic or Frequent Respiratory Issues

or Biting Flies \* Swollen Lymph nodes \* Weight Loss

\* Lupus or other Collagen-vascular Disease \* Bad Breath \* Stubborn Constipation

\* Bites or Stings Greatly Swell and Redden \*Forgetfulness \* Calf Cramps

**COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS**

**Matthew Alfs, M.H., R.H. (A.H.G.)**

(This Statement is required by Section 146A.11 of the Minnesota Statutes.)

1. Name & Contact Information of Unlicensed Complementary and Alternative Health Care Practitioner (the "Practitioner"): Matthew Alfs, Clinical Herbalist, Midwest Herbs & Healing, 2345 Rice St., Suite #203, Roseville MN 55113; (651) 484-0452.

2. Qualifications of Practitioner: Master-Herbalist (M.H.) diploma from Wild Rose College of Natural Healing (Calgary, Ontario) (2-year program, from 1997-99); supplementary education in Traditional Chinese Medicine’s analytical techniques at the American Academy of Acupuncture and Oriental Medicine (from 2000-2001); peer-reviewed Registered-Herbalist (R.H.) status accorded by the American Herbalists Guild for educational and clinical excellence (2002).

**THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.**

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis nor recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

3. Supervisor of Practitioner & Complaints. As a complementary and alternative health care client (a "Client"), you have the right to file a complaint with a supervisor, where such exists. Any such complaint should be directed to the attention of the supervisor, and be in writing, and should include supporting details sufficient to permit an investigation into the complaint to be commenced. In this particular case, there is no direct supervision of the practitioner. But the American Herbalists Guild (PO. Box 3076, Asheville, NC 28802-3076; Phone: 617.520.4372) is, in their words, “willing to act as an informal liaison between a complaining party and a practitioner until more appropriate provisions are established. The information will be reviewed and an attempt made to facilitate meaningful and rational communication to resolve the issue.”

4. Office of Complementary and Alternative Health Care Practice. Office of Complementary and Alternative Health Care Practice, Health Occupations Program, PO Box 64882  
Saint Paul, MN 55164-0882. Phone number: 651-201-3721 Fax: 651-201-3839 TTY: 651-201-5797. As a Client, you may file any complaints with said office.

5. Fees, etc. The Practitioner's fees are billed and due upon completion of services rendered, and are as follows: $150 for the initial visit; $1 a minute for follow-up visits. No insurance companies have agreed to reimburse the Practitioner. The Practitioner does not contract with any health maintenance organizations to provide service. The Practitioner does not accept Medicare, medical assistance or general assistance medical care. The Practitioner is not willing to accept partial payment, or to waive payment.

6. Notice of Changes in Services or Charges. As a Client, you have the right to reasonable notice of changes in services or charges.

7. Theoretical Approach. In general, the Practitioner's choice of modalities depends on your needs as a Client. However, the Practitioner typically uses one or more of the following healing modalities in combination: Herbology or herbalism; healing practices using food, food supplements, and nutrients. To guide his specific choices, the Practitioner’s case analysis typically incorporates several or all of the following tools: A review of intake forms; questioning and listening; nondiagnostic iris analysis; nondiagnostic scleral analysis; nondiagnostic muscle testing; nondiagnostic pulse-taking, nondiagnostic tongue analysis; and non-diagnostic facial analysis (physiognomy).

8. Right to Information. As a Client, you have the right to complete and current information concerning the Practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.

9. Treatment. As a Client, you may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the Practitioner.

10. Client Records/Transactions. Client records and transactions with the Practitioner are confidential, unless release of these records is authorized in writing by you as the Client, or otherwise provided by law.

11. Access to Records. As a Client, you have the right to be allowed access to records and written information from records in accordance with Section 144.335 of the Minnesota Statutes.

12. Other Services. Other services may be available in the community. See local telephone directories.

13. Right to Choose, etc. As a Client, you have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

14. Coordinated Transfer. As a Client, you have the right to coordinated transfer when there will be a change in the provider of services.

15. Refusal of Services. As a Client, you have the right to refuse services or treatment, unless otherwise provided by law.

16. Assertion of Rights. You have the right to assert your rights without retaliation.

*Acknowledgment by Client*

I hereby attest that I have received a copy of The Complementary and Alternative Health Care Client Bill of Rights in relation to services to be provided to me by Matthew Alfs, as required by Section 146A.11 of the Minnesota Statutes.

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Signature Print Name Date

**CANCELLATION POLICY**

**for**

***Matthew Alfs, M.H., R. H. (A.H.G.)***

***Clinical Herbalist***

2345 Rice St., Suite 203

Roseville, MN 55113

Phone: 651-484-0452

Fax: 651-484-0426

You have contracted with your practitioner for an allotted amount of time. A cancelled appointment entails lost revenue for your practitioner unless it is able to be filled, which usually cannot be done within 48 hours. Therefore, at least a 48-hour notice of cancellation (made during business hours) is required should you need to cancel your appointment. If a cancellation is made less than 48 hours before the appointment, you may be billed for the missed appointment, at the discretion of this office.

Your compliance is much appreciated. Please sign below, acknowledging your receipt and understanding of this policy.

I have read and understand the above information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Privacy Policy of**

**Matthew Alfs, M.H., R.H. (A.H.G.),**

**Clinical Herbalist**

1. Information on you and your health is available to you upon request. A copy of our file can be made available to you.

2. No one besides you, Matthew Alfs, and his office staff has access to information about you or your health history without your written consent.

3. Your file/chart is stored outside of access to others.

4. Our computer screen is kept out of view of others and is protected by a password.

5. No information about your health is ever left as a message on any answering machine.

**I, the below undersigned, acknowledge that I have received this policy statement.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_