LaShay Canady, President
ARCB Certified Reflexologist
Certified Medical Herbalist
Correspondence to:
13918 E. Mississippi Ave Ste 129
Aurora, CO 80012
720.224.9117 fax
www.thebossgrp.net

Client Appointments:
15200 E Girard Ave, Ste 2600
Aurora, CO 80014
303.695.7695 o / 303.886.0673 c
herbalist@thebossgrp.net

Initial Visit:
Return visits:

*****Cancellation Policy:*****
So that I may best serve my clients, 24 hours is required for cancellation. You will be charged the full session with less than 24 hours notification. Thank you in advance.

HEALTH HISTORY QUESTIONNAIRE (5-PAGES)

Email address: **Cell phone:**

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Best mode of communication: ☐ Email ☐ Snail Mail ☐ Work phone ☐ Home phone ☐ Cell phone ☐ Text message	
Main reason you are here:	**Second reason you are here:**

*******Mailing address, best phone number to use:**

PERSONAL HEALTH HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR HOLISTIC HEALTH RECORD.

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Past Medical History (and when diagnosed):		
	☐ Allergies	☐ Seizures
	☐ Cancer	☐ Hepatitis
	☐ Thyroid disease	☐ Heart Disease

List any medical problems that doctors have diagnosed (e.g. Diabetes, Hypertension, MS, Ulcers, Stroke, High cholesterol, etc)

Current Weight: Desired Weight: Height:

Surgeries (e.g. Tonsils/Adenoids, Coronary artery bypass, Appendectomy, Hysterectomy, C-Section, Gall Bladder removed, etc)

Year	Reason	Any challenges from surgery?

Other hospitalizations

Year	Reason	Any challenges from hospitalizations?

Have you ever had a blood transfusion? If so, how many?:	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs (such as vitamins and inhalers)		
Name the Drug	Since when?	How effective has this been for you?
Allergies to medications or other substances		
Name the Drug (e.g. Penicillin, Sulfa, contrast dye)	Reaction You Had (e.g. rash, trouble breathing)	

HEALTH HABITS AND PERSONAL SAFETY

REMINDER: ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?	****PLEASE FILL OUT THE FOOD DIARY AND TRACK 3 DAYS				
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol? **(IF NO, MOVE TO TOBACCO)**				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco? **(IF NO, MOVE TO DRUGS)**				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs? **(IF NO, MOVE TO SEX)**				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active? **(IF NO, MOVE TO PERSONAL SAFETY)**	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

REMINDER: ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

	AGE	SIGNIFICANT HEALTH PROBLEMS		**AGE**	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

*****WOMEN ONLY

REMINDER: ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Age at onset of menstruation: Age at menopause:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
**Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any **blood or unusually** substance in your urine?	☐ Yes	☐ No
Any problems with control of urination OR pain with urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

*****MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowels	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

THE B.O.S.S. GROUP LLC

LaShay Canady

B.S. – Holistic Health & Wellness
ARCB Certified Professional Reflexologist
Certified Master Herbalist
Holistic Health Specialist

The herbals formulas, the diet and internal exercises suggested during this consultation are NOT to be used as an alternative to professional medical treatment. I do not attempt to give any medical diagnosis, treatment, prescriptions, or suggestions for medications in relation to any human disease, pain, deformity, physical or psychological condition. Most of the health practices I discuss have been used by Traditional Chinese Herbalists and Western Herbalists successfully for thousands of years.

I am not a medical doctor. I am a Certified Medical Herbalist. I am an ARCB Certified Reflexologist.

A certified Herbalist and/or Reflexologist does not treat disease. Rather, we emphasize the balancing and strengthening of the body's vital energy (qi) so the body can heal itself. Proper foods, herbs and exercise can balance the energy in the body without any side effects. The correction of one function of the body at the expense of another does not re-establish the energy balance within the body, which is necessary to integrate mind, body and spirit. Therefore, the scope and purpose of a Master Herbalist is completely different from that of medical science. In traditional medicine, we do not treat symptoms but seek the cause of a disease.

Credentials:
LaShay Canady is certified in both Western and Chinese herbology. She studied at Just For Health School of Reflexology and Healing Arts and is certified as a Master Herbalist, as well as a Certified Reflexologist by the American Reflexology Certification Board (#B01219). She is an Alumni of Metropolitan College at Denver where she completed her own self-designed Bachelors of Science degree: Holistic Health and Wellness. LaShay is the proud owner of The B.O.S.S. Group LLC. (B.O.S.S. stands for the Beauty Of a Solo Spirit)

Any reference to western pathological terms during this consultation does not mean I am attempting to provide a cure for that disease. I am only providing a clear reference to further the comprehension of the client.

All information we exchange is completely confidential. Your case will not be discussed with other practitioners except with your permission.

Sources for high quality Chinese and Western herb formulas can be difficult for the layperson to obtain. I do provide you with the highest quality products available to practitioners. You may purchase other recommended supplements from your own sources and I will recommend retail brands that are comparable and available to the consumer if you prefer.

I have read the above information and fully understand the purpose of this consultation. Before signing this release form, all questions pertaining to the above information have been answered to my complete satisfaction.

Name (print):

Phone:

Date:

SIGNATURE (print this out and put an original signature): _____

PLEASE BRING THIS FORM WITH YOUR COMPLETED QUESTIONNAIRE
YOU MAY ALSO FAX THE QUESTIONNAIRE AND THIS FORM TO 720.224.9117