INFORMED CONSENT FORM AND AGREEMENT FOR HERBAL CONSULTATION INTUNE FITNESS, HERBALIST & HEALTH COACH TONICA ROSS BENTON

ABOUT YOUR HERBAL CONSULTATION

During your herbal consultation I will focus on educating you about ways you can enhance your body's innate healing capacity The consultation is an opportunity to learn natural approaches to health and receive education about the use of herbs for greater health and well-being. An herbal consultation can help you address a specific health concern or simply help you optimize your energy and vitality.

Before your first visit, you will need to complete a questionnaire about your health and lifestyle. During the consultation I will evaluate patterns in your health and individual constitution and make recommendations for improvements. You will receive written recommendations which may include personalized custom herbal formulas, supplements, food and lifestyle changes. These recommendations are educational and are intended to support and facilitate your own informed-decision making and empower you in your journey towards better health. A given herbal program may be followed from 1 to 3 months or more, depending on the individual and their health status.

If during your consultation, I determine that your needs are not within the scope of my training and specific expertise, I will refer you will to another practitioner. You may also be referred to other practitioners who offer other types of support that may complement the use of herbal remedies.

THE ROLE OF AN HERBALIST

Herbalists are not licensed practitioners in the United States or in the State of Ohio. I do not diagnose, treat disease or prescribe treatment. I am not a licensed medical doctor or naturopathic medical doctor. My focus is on educating you about abut ways you can enhance your body's innate healing capacity and optimize our health. The services I provide are not intended to replace the those of a licensed physician or other healthcare provider. I am happy to be part of your healthcare team and will work with any of your healthcare practitioners to support you.

YOUR RESPONSIBILITY

You agree to make you own informed decisions concerning the information provided and are solely responsible for your decisions and actions based on that information.

PAYMENT

Payment is due at the time of your visit. The price of your visit does not include herbs, supplements or other products that may be recommended during your visit. If you are unable to afford the cost, please let us know. We can offer a sliding scale payment or payment plan. We accept payment in cash, cash app, check or credit card (Visa, Mastercard or Discover).

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CANCELLATION POLICY

If you need to reschedule or cancel your appointment, please provide us with at least 24 hours advance notice to avoid a cancellation fee. If you cancel with less than 24 hours' notice or fail to show up for a scheduled appointment, you will be charged $50 for an initial consult or $25 for a follow-up visit.

Plans & Services: Customize herbal plan $50. Herbs and supplements separate.

PRIVACY

The information shared with your herbalist is confidential. Your information will only be disclosed with your written consent, if legally mandated or in the event of threatened suicide, child or elder abuse.

I _____ have read this document, INFORMED CONSENT FORM AND AGREEMENT FOR HERBAL CONSULTATION. I understand the purpose and scope of the client and herbalist relationship. I understand that TONICA ROSS BENTON is not a licensed practitioner, medical doctor or naturopathic medical doctor, and does not diagnose, treat disease or prescribe treatment. I understand that an herbal consultation is not a replacement for the care of a licensed physician or other healthcare provider. I am seeking an herbal consultation solely for educational purposes and my own informed decision-making and agree that I am solely responsible for my decisions and actions based on the information provided.

PRINTED NAME:

_____

SIGNATURE:
_____ DATE: _____

PERSONAL HEALTH PROFILE

NAME: _____

DATE OF BIRTH: _____ **PREFERRED PHONE NO.:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMAIL ADDRESS: _____

REFERRED YOU? _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ **PHONE NO.:** _____

KEY AREAS OF INTEREST OR CONCERN

List the main health topics or concerns you want to discuss:

1) _____

2) _____

3) _____

4) _____

5) _____

Have you seen a medical doctor or other healthcare practitioner regarding any of these topics or concerns? If so, please specify the concerns and the practitioner:

Concerns: _____

_____

Practitioner Names: _____

_____

Medications, Supplements & Herbs: Please list all prescription and over-the counter medications, supplements, and herbs you are currently taking:

Name: Dosage: For What Purpose:

_____

_____

_____

_____

Attach additional page if necessary.

Allergies: Do you have allergies to medications, food or herbs? ❑ **No** ❑ **Yes** If yes, please list what you are allergic to:

_____

_____

Lifestyle & Personal Habits:

Height: _____ Weight: _____ Is your weight stable? ❑ **No** ❑ **Yes**

Do you drink alcohol? ❑ **No** ❑ **Yes** Frequency? _____

Do you use tobacco or vape? ❑ **No** ❑ **Yes** Frequency? _____

Do you use cannabis or CBD? ❑ **No** ❑ **Yes** Frequency? _____

Do you use recreational drugs? ❑ **No** ❑ **Yes** Frequency? _____

Do you drink coffee or tea? ❑ **No** ❑ **Yes** How much? _____

Do you exercise regularly? ❑ **No** ❑ **Yes** Frequency? _____

Type of exercise? _____ Duration? _____

What do you like to do for relaxation? _____

Do you work? ❑ **No** ❑ **Yes** If yes, what kind of work do you do? _____

Dietary Habits - Describe a Typical Day's Menu:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Desserts: _____

Beverages: _____

Do you have any known or suspected food sensitivities? ❑ **No** ❑ **Yes** If yes, to what? _____

_____

Family History:

Do you have any family members (Mother, Father or Siblings) who have had any of these conditions?

❑ Alzheimer's Disease ❑ Auto-Immune Condition ❑ Dementia ❑ Cancer ❑ Diabetes

❑ Dementia ❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol ❑ Mental Illness

Personal History:

Have you had any major injuries or accidents? ❑ **No** ❑ **Yes** If yes, please list with dates:

_____

Have you had any major illness, surgery or hospitalizations? ❑ **No** ❑ **Yes** If yes, please list with dates:

_____

Are you pregnant or could you be pregnant? ❑ **No** ❑ **Yes** If yes, how many months? _____

Indicate whether you have had of the following experiences. **Use a "C" for CURRENT if it happened in the last three months or a "P" for PAST if it happened in the past.**

Digestive System:		
___ Abdominal pain ___ Belching ___ Constipation ___ Diarrhea ___ Food Cravings ___ Gall stone ___ Gas or Bloating	___ GERD's or Heartburn ___ Hemorrhoids ___ Hepatitis ___ IBS ___ Nausea ___ Poor Appetite ___ Ulcers	___ Other: _____
Number of bowel movements daily? _____ Are they? ❑ Loose ❑ Normal ❑ Hard ❑ Incomplete		
Nervous & Endocrine System:		
___ Anxiety ___ Brain fog / Cloudy thinking ___ Depression ___ Difficulty concentrating ___ Fatigue ___ Headaches ___ Hot flashes ___ Hormonal imbalance	___ High Stress ___ Irritability ___ Mental illness ___ Mood swings ___ Numbness or tingling ___ Poor sleep ___ Poor memory ___ Racing thoughts	___ Thyroid dysfunction ___ Other: _____

Indicate whether you have had of the following experiences. **Use a "C" for CURRENT if it happened in the last three months or a "P" for PAST if it happened in the past.**

Immune:		
___ Allergies ___ Auto-Immune condition ___ Cancer ___ Chemical sensitivities ___ Chronic infection	___ Hives ___ Herpes ___ Fevers ___ Frequent colds or infection ___ Swollen glands	___ Other: _____
Musculoskeletal:		
___ Back pain ___ Joint pain ___ Muscle pain ___ Muscle weakness ___ Neck pain	___ Osteoarthritis ___ Osteoporosis ___ Reduced range of motion ___ Rheumatoid arthritis ___ Stiffness	___ Other: _____
Cardiovascular:		
___ Chest pain ___ Cold hands and feet ___ Dizziness ___ Fainting ___ High blood pressure	___ High cholesterol ___ Irregular heartbeat ___ Low blood pressure ___ Poor circulation ___ Varicose veins	___ Other: _____
Respiratory System:		
___ Asthma ___ Bronchitis ___ Cough ___ Difficulty breathing ___ Frequent infections	___ Pneumonia ___ Respiratory infection ___ Seasonal allergies ___ Sinus congestion ___ Shortness of breath	___ Other: _____
Urinary System:		
___ Frequent urination ___ Incontinence ___ Kidney stone ___ Painful urination	___ Urgency ___ Urinary Tract Infection ___ High blood pressure ___ Water retention	___ Other: _____
Skin & Hair:		
___ Acne ___ Boils ___ Eczema ___ Frequent itching	___ Frequent rashes ___ Hives ___ Hair loss ___ Poor healing sores/wounds	___ Other: _____

Indicate whether you have had of the following experiences. **Use a "C" for CURRENT if it happened in the last three months or a "P" for PAST if it happened in the past.**

Reproductive – Female:		
___ Absence of menstruation ___ Breast lumps ___ Breast pain/tenderness ___ Cramps ___ Difficulty conceiving ___ Endometriosis ___ Heavy bleeding ___ Hot flashes	___ Irregular cycles ___ Menopause ___ Ovarian Cysts ___ PCOS ___ PMS ___ Unusual bleeding ___ Unusual discharge ___ Uterine fibroids	___ Other: _____
Length of cycle: _____ Duration of bleeding: _____ Age at Menopause: _____ Use birth control? ❑ **No** ❑ **Yes** How long? _____ Use HRT ❑ **No** ❑ **Yes** How long? _____		
Reproductive - Male:		
___ BPH ___ Elevated PSA levels ___ Erectile dysfunction ___ Low sperm count	___ Prostate Cancer ___ Prostatitis ___ Testicular pain	___ Other: _____

Is there anything else you feel is important?

_____

_____

_____

Almost finished! Please complete the form "Determining Your Constitution" on the next page.

Determining Your Constitution

As you go through this form, check the box based on what feels like the *most accurate long-term tendency for you.* This will give the clearest depiction of who you are. Usually this will be only one of the 3 options provided in each section. Sometimes two will feel equally accurate; mark them both. Very occasionally all three will feel equally accurate; mark all three answers. Tally up your answers at the end of each column to discover your unique combination.

	✓	TYPE 1	✓	TYPE 2	✓	TYPE 3
BODY FRAME		long and lean		moderate		substantial
BODY WEIGHT		tends to be underweight		tends to be moderate		tends to be overweight
SKIN		dry, rough, cold, thing		soft, warm, fair, moles and freckles, flushes easily		oily, thick, cool, pale
HAIR		dry, rough, brittle, curly or kinky, course, light brown		thin, fine, straight, light-colored, early gray, balding		thick, oily, strong, healthy
TEETH		irregular, protruding, crooked, thin gums, tendency to tooth decay		regular, moderate, soft gums, yellowish		big, white, strong, healthy
EYES		small, darting, brown		moderate, sharp, intense, greenish		blue, big, caring, thick eyelashes
LIPS		thin		moderate, red		full, pale
NECK		long and thin		moderate		short and thick
JOINTS		dry, cracking, cold, bony		moderate		well lubricated, large, not visible
MUSCULATURE		slight and stiff, tendon		medium, flexible,		firm, stout
APPETITE		variable, scanty, can miss a meal without noticing		good, excessive, gets hangry (hungry + angry) if a meal is missed		low but steady
THIRST		variable		excessive		steady
SWEATING		variable to none		excessive, odorous		moderate to none, no odor
SLEEP		wakes easily, difficult to fall asleep		falls asleep easily, stays asleep, has difficulty sleeping in warm weather		sleeps long and deep, has difficulty waking up
ELIMINATION		irregular, dry, hard, tends to constipation		regular, loose, soft, tends to diarrhea		slow, regular, oily
PHYSICAL ACTIVITY		fast and very active		moderate and competitive		lethargic, slow
DREAMS		often fearful, flying, running, jumping, dancing		often fiery, passionate, angry, violent		often calm, romantic, watery of relationships
EMOTIONS		unpredictable, anxious, insecure		irritable, jealous, blaming, judgmental, critical, angry		calm, quiet, loving
MIND		restless, active		aggressive, intelligent, intense		calm
FAITH		changeable		determined, can be fanatical		steadfast
MEMORY		recent good, long-term poor		sharp		slow but steadfast
INTERESTS		recreating, running, dancing, talking		competitive sports, debate, politics		family and social gatherings, cooking, collecting
FINANCES		poor, spends money on cheaply-made items		moderate, spends money on well-made items		rich, saves well
ACHIEVING GOALS		is easily interrupted & distracted		is focused, driven, production-oriented		works slowly and steadily
RELATIONSHIPS		has many casual acquaintances		has intense relationships		has loyal, long-term relationships
WEATHER		averse to cold, windy weather		averse to hot weather		aver to cold, damp weather
REACTION TO STRESS		excites easily, flies apart in all directions		rise to the challenge		rarely gets stressed; plods along
SHOWS AFFECTION		with words		with gifts		with touch
TOTAL:		Vata Type		Pitta Type		Kapha Type