DEEP ROOTS APOTHEKE AND CLINIC

CLINICAL HERBALIST CAMERON STROUSS

DISCLOSURE/INFORMED CONSENT FORM

I _____, hereby attest and agree to the following:

1. I understand that PRACTIONER Cameron Strouss is participating in a mentorship program to enhance her/his clinical herbalist skills toward professional registration with the American Herbalists Guild and will review consultation cases with her mentor, who is a professional member of the American Herbalists Guild. In order to prove that she has met requirements for clinical hours, PRACTITIONER Cameron Strouss will keep a separate list of client names and contact information, along with dates when she/he met with each client for consultation or follow-up appointments. This record will be submitted to the American Herbalists Guild (AHG) as part of her professional application. There will be no information concerning the nature or details of the wellness consultation included in this record. Some clients may be contacted by the AHG to verify that the consultation did indeed take place. During this contact, the AHG representative will not ask any questions about the nature of the consultation.

2. I am aware that PRACTITIONER Cameron Strouss' training and education includes a Biology Degree from The University of Montevallo, two years of folk herbal training from Darryl Patton at the Southeastern Institute for Traditional Herbal Studies, an Internship with Herb Pharm (a tincture company) and a 10 month long apprenticeship with Thomas Easley RH (AHG) and The Eclectic School of Herbal Medicine and she obtained her Clinical Herbal Certificate.

3. I understand that the services provided by PRACTITIONER Cameron Strouss are restricted to consultation and education and are intended to provide me with information to promote wellbeing. I understand that all evaluations performed by Cameron Michelle Strouss or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits, and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have, and do not replace the diagnostic services offered by licensed physicians.

4. I fully understand that Cameron Michelle Strouss is a lay natural health ADVISOR and TEACHER who deals strictly in helping people to improve their general health and fitness through better nutrition, improved lifestyle, health habits, and positive mental attitudes.

5. I understand that the information I receive from PRACTITIONER Cameron Strouss is not intended to diagnose, treat, or cure any disease or condition. I fully understand that Cameron Michelle Strouss is NOT a licensed physician, and cannot diagnose diseases, prescribe drugs, or recommend treatments for specific disease conditions. I understand that Cameron Michelle Strouss neither claims, nor implies, that any instruction, advice, counsel, suggestions, recommendations, services, or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent, or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems, and otherwise improving general health and fitness.

6. I understand that it is my constitutional right to decide how I wish to care for my health. PRACTITIONER Cameron Strouss has not suggested that I cease any current medical care or therapies. I have sought PRACTITIONER Cameron Strouss' advice and I recognize that I am free to act upon her recommendations as I see fit, and, as such, release her of all responsibility for my actions and any consequences thereof, both now and in the future. I understand that Cameron Michelle Strouss or her representatives will not suggest that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Cameron Michelle Strouss or her representatives responsible for the consequences of my decisions.

7. I understand that Cameron Michelle Strouss believes that genuine healing comes only from God, and that God has provided simple and natural methods such as rest, nutrition, herbs, exercise, attitude changes, and touch to help people recover and maintain their health. I further understand that Cameron Michelle Strouss shares these methods with others as part of her God-given and constitutional rights of freedom of speech and freedom of religion.

8. I am here on this and subsequent visits solely on my own behalf and not as an agent of federal, state, or local government agencies for purposes of investigation or entrapment.

9. I understand that payment is due at the time that consultation services are rendered.

I have read and understand the foregoing and agree to the terms and conditions set therein.
I have received a copy of this agreement.

Dated this _____ Day of _____, 20___

_____

Client Signature

Deep Roots Holistic Health Club - Membership Application

Deep Roots Holistic Health Club (hereinafter referred to as "DRHHC") is a private membership club for the purpose of allowing people to learn, discuss and share information, herbs and knowledge about natural health, herbalism and nutrition.
Membership dues for DRHHC are $5 per year. Please complete this membership application and return it with annual membership dues for one year. Membership in DRHHC permits participation in natural health-related activities and discussions with other members as well as educational discussions and consultations with herbalists. The cost of any consultation with herbalists and/or any herbal preparations (tinctures, salves, etc.) is not included in the annual membership dues.

New Member Application Info:

First Name:_____

Last Name:_____

Address:_____

Phone:_____

Email:_____

New Member_____ Renewing Member_____

I, the undersigned, in accordance with the bylaws of DRHHC, hereby apply for membership in DRHHC. I am interested in herbs and natural health and wish to learn more about this subject, work with herbs and nutrition for my own personal health and contribute my own information and personal experiences as appropriate and relevant. I understand that participating in the club's activities, discussions and consultations is in no way a medical diagnosis or treatment of any illness or injury. Nor is participation in club activities, discussions or consultations any type of substitution for consultation with a medical doctor about a medical condition that I may have.

Signature of Applicant:_____

Date:_____

----------*ADMINISTRATION USE*----------

*Reviewed and Approved by:*_____

*Date of Approval:*_____

PERSONAL INFORMATION

Name_____Sex_____

Date of birth_____Age_____

Address:_____

City_____State_____Zip code_____

Email Address_____

Phone(day)_____(evening)_____

Occupation_____

Height_____Weight_____ Ideal Weight_____Last time weighed ideal weight _____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so. Please complete the questionnaire as thoroughly as possible. Thank you.

How did you hear about us?_____

Do you have any allergies we should know about?_____

Is there any reason you should not take formulas made with alcohol (in recovery, liver issues, religious reasons,

preference)?_____

I. Your Story:

I would love to know what has brought you here today and how I can best serve you on your journey towards health. How are you feeling? What is your primary concern? What are you hoping to achieve in your time as a client here?

II. Symptoms:

	Fever		**Cough**
	~ w/ Chills?		~ wet?
	~ causing insomnia?		~ dry?
	~ too high?		~ yellow mucous?
	Ear Ache		~ clear/white mucous?
	Headache		~ wheezing?
	Body Ache		~ shallow?
	Sinus Infection		~ deep?
	~ clear/ thin/ runny?		**Sore Throat**
	~ clear/thick?		**Burn**
	~ yellow/ thick?		**Rash**
	~ yellow/ thin/ runny?		**Diarrhea**
	Eyes		**Vomiting**
	~runny weaping?		**Abdominal Pain**
	~ recent exposure to pink eye?		**Emotional Trauma**
	Cold Sores?		
	Immunizations?		**Upcoming Surgeries?**
	Other:		

Do you have anything else that you would like to address today?

Deep Roots Apotheke and Clinic

Case Review Form

Clinician: Cameron Strouss, Clinical Herbalist

Case #: Date:

Client Information

Name:

Gender: Age: Height: Weight:

Occupation:

Reason for visit:

Medical History

Drug History: Current Drugs, Herbs and Supplements:

Known Allergies to Drugs, Herbs, Foods, Etc.:

Past Surgeries/Hospitalizations:

Elimination Habits:

C.C./Quotes:

Case Summary

Case Analysis:

Protocol Strategy:

Dietary Recommendations:

Primary Herbal Recommendations:

Other Recommendations:

Notes on Possible Future Recommendations:

Referrals to Other Practitioners:

A. Pulse Analysis

Pulse: Rate: _____ ☐Rapid ☐Normal ☐Slow

Width: ☐Thin ☐Full / Normal ☐Wide / Atonic ☐Wiry ☐Weakly Tense

Strength: ☐Weak ☐Strong / Normal ☐Hard ☐Bounding

Height: ☐Floating ☐ Normal ☐Deep

Other:

☐Rolling / Slippery ☐Resistant ☐Non-resistant

Other:

Positions: Left: 1 2 3

Right: 1 2 3

B. Tongue Analysis

Body:

Color: ☐Bright Red ☐Dark Red ☐Pink ☐Pale ☐ Other:

Moisture: ☐Damp ☐Normal ☐Dry ☐Other:

Characteristics: ☐Swollen ☐Quivering ☐Smooth
☐Scalloped ☐Withered ☐Furry/Hairy
☐Cracked ☐Geographic ☐Red Tip
☐ Thin ☐Crooked ☐Glossitis
☐ Thick

Other:

Moss: ☐Absent ☐Light ☐Heavy ☐Rooted ☐Unrooted

Color: ☐White ☐Yellow ☐Brown ☐ Other: