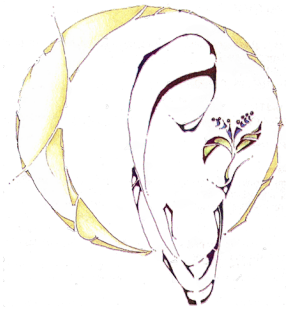

Luna Herb Co.

Kristine Brown
Practicing Community Herbalist
8801 State Route 162, Troy, Illinois 62294
herbalist@lunaherbco.com
618-530-1224

Office Use Only:

Client Number:_____

Herbal Intake Form

Name:_____ Birth date: _____/_____/_____

Address: _____

_____

Telephone: (home)_____ (cell) _____

Best time(s) to call:_____

Email:_____Preferred form of contact: _____

Occupation: _____ Circle one: Full time / Part time

Hours/days your work: _____

Age: _____ Height: _____ Weight: _____lbs Gender: Male / Female / _____

Who do you share your home with: _____

Number of children: _____ Age(s): _____

Please list all physicians and other healthcare providers or consultants (such as Acupuncturist, massage therapist, etc) you see on a regular basis:

Name Location Type of Service

_____

_____

_____

_____

_____

Family Medical History:

Please describe any relevant or major health-related issues:

Father: _____

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Other family members with pertinent issues, or recurring family health trends:

_____

_____

YOUR CHILDHOOD

Were you breastfed? YES / NO If yes, how long?_____

Were you a happy child? YES / NO

How would you describe your childhood? _____

_____

How would you describe your parents? _____

_____

Did you like your school? Elementary YES / NO Middle YES / NO High School YES / NO

Were you ever bullied? YES / NO If yes, how long and was it resolved in a positive manner?

_____

Were there any traumatic events in your childhood? YES / NO If yes, please explain:

_____

_____

_____

PRESENT HEALTH STATUS

Do you currently smoke tobacco? YES / NO If so, how many cigarettes/day? _____

If not, have you ever been a smoker in the past YES / NO

For how many years did you smoke? _____When did you quit? _____

Do you currently drink alcohol? YES / NO If so, list type, quantity, and frequency:

_____

Did you consume alcohol in the past YES / NO When did you quit alcohol? _____

If so list type, quantity and frequency:_____

List form and frequency of any regular exercise: _____

How is your digestive system overall, do you experience indigestion, gas, constipation, diarrhea, bloating or other? _____

_____

How often do you have a bowel movement? _____

How often do you urinate and what is the character of your urine, i.e., light, dark, strong odor?

_____

Do you have headaches?_____How often?_____What are they like?_____

_____

Do you know what causes them?_____

How often do you brush your teeth? _____

How long do you brush? _____ Do your gums bleed when you brush? Yes / NO

How often to you change your toothbrush? _____

Do you floss? YES / NO If yes, how often? _____

Do you oil pull? YES / NO If yes, how often and how long? _____

Do you have all your wisdom teeth? YES / NO Do you have all your molars? YES / NO

Do you use mouthwash? YES / NO What brand? _____

What brand / type of toothpaste do you use? _____

Is your mouth dry? YES / NO Do you ever have a 'funny taste'? YES / NO How often? _____

Does your breath smell? YES / NO How often? _____

What does it smell like? _____

Do you have any fillings? YES / NO How many? _____ What type? _____

Do you have any caps, crowns or prostheses? YES / NO Do they fit correctly? YES / NO

Have you ever had a root canal? YES / NO How many? _____ When? _____

Does your mouth affect your food choices? YES / NO If yes, why/how? _____

_____

Did you have braces? YES / NO

Check each column where symptoms apply and elaborate in space provided below if necessary. Please indicate with a √ any experiences below that you sometimes experience; two checks √√ for those which occur often; and use three checks √√√ for those which are a major concern.

Cardiovascular
_____High Blood Pressure
_____Low Blood Pressure
_____Pain in Heart
_____Poor Circulation/cold extremities
_____Swelling in Ankles/joint
_____Previous heart stroke/murmur
_____High Cholesterol

Muscles/Joints
_____Backache/upper or lower
_____Broken Bones
_____Mobility Restriction
_____Arthritis/Bursitis

Eyes, Ears, Nose, and Throat
_____Hearing Loss/Ringing Ears
_____Asthma
_____Ear Aches
_____Eye Pains, Dry/Wet
_____Failing vision
_____Hay Fever
_____Sinus Infection
_____Sinus Congestion
_____Sore Throat
_____Tonsils

Mouth/Dental
_____Cavities
_____Gingivitis
_____Halitosis
_____Crumbling teeth
_____Ulcers/canker sores
_____Cold sores

Respiratory
_____Chest Pain
_____Difficulty breathing
_____Cough
_____Tuberculosis
_____Congestion

Gastro-Intestinal
_____Belching
_____Colitis
_____Constipation
_____Abdominal Pain
_____Liver Problems
_____Gall Stones
_____Ulcers
_____Indigestion

Urinary/Kidney
_____Itchy Ears/eyes
_____Emotional Insecurity
_____Excessive Urination
_____Water Retention
_____Burning Urine
_____Kidney Stones
_____Lower Back Pain
_____Dark circles under eyes

Skin
_____Slow to heal
_____Rashes
_____Acne
_____Psoriasis
_____Eczema
_____Moles
_____Bruise easily
_____Dryness
_____Varicose veins

Sleep
_____Night sweats
_____Restless sleep
_____Nightmares
_____Wake up tired
_____Insomnia
_____Difficulty falling back to sleep
_____Waking in the night

Miscellaneous
_____Usually feel Cold/Cool
_____Usually feel Hot/Warm

Male Reproductive System
_____Prostate inflammation/swelling
_____Prostate cancer
_____Infertility issues
_____Benign prostate hypertrophy
_____Pain or difficulty urinating
_____Venereal disease
_____Impotence or erectile problems
_____If over 50, annual PSA screening?
If yes, last screening: _____

Common Physical Activities

__Desk Sitting (how long)
__Sitting in a car (how Long)
__Calisthenics
__Swimming
__Walking
__Tai Chi
__Bike Riding
__Tennis
__Other_____

__Standing (how long?)
__Jogging/Running
__Aerobics
__Weight Lifting
__Yoga
__Hiking
__Horseback Riding
__ BendingLifting

Do any of the conditions above aggravate a current health condition?_____

Have you had any operations? YES / NO Please list all operations and dates:

_____

_____

_____

_____

Any major injuries/accidents? YES / NO What and when? _____

_____

_____

Any major illness or hospitalizations? YES / NO What and when? _____

_____

_____

_____

Any other health issues not covered above?_____

_____

_____

_____

_____

DIETARY INFORMATION

Please check each item listed below if it is included in your daily - or usual - diet (mark D=daily, W=weekly, M=monthly, N=never):

___Red Meat	___Butter	___Candy bars/chocolate
___Fish	___Milk	___Coffee
___Poultry	___Cheese	___Black Tea
___Pork	___Yogurt	___Herbal Tea
___Misc. Meat_____	___Sugar	___Alcohol
___Fruits	___Honey	___Soda
___Vegetables	___Baked Goods	___Diet Soda
___Raw Foods	___Baked Goods	___Vitamins
___Grains	___Deserts	___Protein Supplements
___Nuts	___Crackers	___Food Supplements
___Seeds	___Chips	___Processed foods/snacks
___Fermented Foods	___Wheat	___Corn

Dietary Information
Describe below your typical meals. Please be as specific as possible. For example, Instead of "oil" list type of oil, such as olive, corn, etc. Instead of "bread" list whether white or whole grain, etc. Instead of "vegetables" list type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include beverages, type and quantity (two cups of coffee, one glass of orange juice, etc.)

What's a good day of eating like?

Breakfast: _____

_____

A.M. snack(s): _____

Lunch: _____

_____

P.M. snack(s): _____

Dinner: _____

_____

Evening snack(s): _____

Daily water consumption (# glasses/quantity/day): _____

What's a bad day of eating like (meals on the run, etc):

Breakfast: _____

_____

A.M. snack(s): _____

Lunch: _____

_____

P.M. snack(s): _____

Dinner: _____

_____

Evening snack(s): _____

Daily water consumption (# glasses/quantity/day): _____

How many times a week do you have a good day_____Bad day_____of eating?

Please list any known food allergies/sensitivities (attach additional sheets if needed):

Food Describe Reaction

_____

_____

_____

If everything was good for you, what would you want to eat (What do you crave)?_____

_____

Have you ever had herb tea?_____ Any other herbal supplements? Please list if yes:

_____

_____

_____

Current State of Emotions and Feelings
Please take a moment to answer the following questions:

Are you able to express your feelings and emotions? _____

Is there an excess of stress in your life? _____

What is causing the stress?_____

Are you satisfied with your job? _____

If in a relationship, are you satisfied with it?_____

If there is one thing in your life you would like to change right now, what is it?_____

_____

Can you change it?_____

Are you a "nervous type" person? _____

What are the things that make you most nervous?_____

Have you a "super woman/superman" complex?_____

Do you sleep well?_____How long each night?_____

Do you nap?_____ How long and often?_____

Do you dream?_____ Do you remember your dreams?_____

Are you satisfied with your general energy level?_____

Do you often feel exhausted and fatigued?_____

Is it easy to wake up in the morning?_____

Please indicate approximate dates and describe the nature of any traumatic experiences you have had in your life, starting with the most current (divorce, loss of lover, loss of job, change of residents, injury, death, etc.) Use additional paper if necessary.

Year Event

_____

_____

_____

_____

_____

_____

Name one thing in life that you do that is really good for you:_____

_____

Name one thing you know you should be doing but don't:_____

_____

What are your passions and interests?_____

_____

What do you do for fun?_____

_____

Supplements and Medications

List all herbs, vitamins, and dietary supplements you currently take, Citing brand name whenever possible and list why you are taking each (please bring all your supplement bottles with you for your appointment): Use additional paper if needed

supplement dosage reason for taking

_____

_____

_____

_____

_____

List all medications you are currently taking and **what they are taken for** (including aspirin, antacids, etc.), indicating whether they are over the counter (OTC) or prescription (P):
Use additional additional paper if needed

Name of Product Used for OTC or P? Dosage Frequency (#/day)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you use any other drugs? Circle any that apply:

marijuana mushrooms ecstasy cocaine LSD heroin other:_____

Have you used any drugs in the past? Circle any that apply:

marijuana mushrooms ecstasy cocaine LSD heroin other:_____

List all medications, herbs, etc., to which you have a known allergy:

_____

_____

What prompted you to seek out an herbalist?

What would you like me to help you change about your health or lack of?

What do you hope to get out of this consultation?

What fears or anxieties do you have about this consultation (if any)?

Anything else you would like to share or add?