KRISTINE BROWN
PRACTICING COMMUNITY HERBALIST

LUNA HERB COMPANY
•HERBAL CONSULTATIONS, THERAPY & REMEDIES•
HAND MADE WITH GRATITUDE IN HONOR OF MOTHER EARTH'S HEALING HERBS

SPECIALLY BLENDED BY LUNA FARM LLC 8801 STATE ROUTE 162, TROY, ILLINOIS 62294
HERBALIST@LUNAHERBCO.COM

Herbal Intake Form

Name:_____

Address: _____

_____

Telephone: (w)_____ (h) _____

Best time(s) to call:_____

Email:_____Preferred form of contact: _____

Occupation: _____ Gender (m/f): _____

Age: _____ Height: _____ Weight: _____lbs Birth date: _____

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

_____

_____

_____

_____

_____

Would you like me to contact them regarding your health plan with me?_____

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:

_____

_____

PRESENT HEALTH STATUS

Do you currently smoke tobacco (y/n)? _____ If so, how many cigarettes/day? _____

If not, have you ever been a smoker in the past (y/n)? _____

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

Do you currently drink alcohol (y/n)? _____ If so, list type, quantity, and frequency:

_____

Did you consume alcohol in the past (y/n)? _____ 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?

_____

Present Health Status

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

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

Skin
_____Boils
_____Bruises
_____Dryness
_____Itching
_____Varicose Veins
_____Skin eruptions

Respiratory
_____Chest Pain
_____Difficulty breathing
_____Cough
_____Tuberculosis
_____Congestion

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

Sleeping Patterns
_____Insomnia
_____Waking in the night
_____Nite sweats
_____Restless sleep
_____Wake up tired
_____Difficulty falling back to sleep

Miscellaneous
_____Usually feel Hot/Warm
_____Usually feel Cold/Cool

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

_____

Do you know what causes them?_____

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? ____What year? _____

Any major injuries/accidents?____ What and when? _____

Any major illness or hospitalizations? ___What and when? _____

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
___Fruits	___Yogurt	___Herbal Tea
___Vegetables	___Sugar	___Alcohol
___Raw Foods	___Honey	___Vitamins
___Grains	___Baked Goods	___Protein Supplements
___Nuts	___Deserts	___Food Supplements
___Seeds	___Chips	___Processed foods/snacks
___Fermented Foods	___Crackers	

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?_____

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?_____

Which of these feelings dominate in your life:

joy happiness anger sadness fear sympathy worry depression

If you were to choose two Emotions, which seem predominant in your life they would be_____and_____

Please indicate approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residents, injury, death, etc.)

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 (please bring all your supplement bottles with you for your appointment):
Use additional paper if needed
supplement dosage

_____

_____

_____

_____

_____

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 are the areas of current complaint that you would like to address with an herbal program?

_____

Luna Herb Company
STATEMENT OF UNDERSTANDING

The human body has the innate power to heal itself. Without this power to self-heal, even the most advanced medications and surgical procedures would ultimately fail. The role of the herbalist in this healing process is to consider the client as a whole person and to consult with the client concerning changes in lifestyle, diet, and supplementation of herbs and/or vitamins to foster an increased state of balance and health, thus maximizing the body's self-healing capabilities.

I practice nutrition related assessment, diagnosis, and therapeutic methods based on the healing system. This scope of practice includes dietary assessment, dietary changes, physical diagnosis related to nutrition (including pulse, palpation, tongue, and observation), interpretation of laboratory values relating to nutrition, dietary counseling, reviewing medical records, recommending diet therapies, recommending nutritional supplements when indicated, and identifying proper treatment strategies.

My approach is to combine numerous alternative healing methods together with the latest scientific findings and clinical practices. Nutrition and herbs are my primary specialty and represent my area of expertise. The degree of incorporation of these systems will vary from case to case. The basic principle is to help the body’s natural capacity to restore balance, health, and harmony. Assessments are focused on identifying patterns and imbalances. Depending on the patient’s wishes, recommendations may incorporate nutrition, herbs, supplements, counseling, exercises and lifestyle. Recommendations may be use to instill physical, emotional, mental, and/or spiritual balance.

I am NOT a Medical Doctor nor do I practice western medical assessment, diagnosis, or treatment. I do not claim to cure disease. Nor do I give advice about pharmaceuticals and medications at any time. I have no objections to my clients being seen or evaluated by their own medical doctor. If you have any questions or concerns about your condition, I highly recommend you discuss it with your physician. I am willing to work as part of a health care team including physicians and other health care providers. If you would like me to work with your physician, please inform you physician also of this wish. I also recommend you inquire and explore any recommendations I provide with any professionals in health care.

Further, I have a herbal/nutritional apothecary in the clinic. I sell many herbal products and some food products for a profit. I dispense them here as a convenience and to ensure patients are receiving the specific, individualized herbal formula they need. I use mostly regional herbs that can be grown and/or wildcrafted in my area. Most of the herbal formulas I personally harvest in the wild or from my gardens and make into preparations by hand. I also use them to create customized herbal formulas to fit the exact profile for what I feel clients need. Clients are not obligated to buy any products here. I encourage clients to buy any supplements wherever it is most convenient for them. The recommended nutritional/herbal supplements are not a replacement for the medications prescribed by your Medical Doctor.

Kristine Brown, Practicing Community Herbalist
Luna Herb Company

Please sign below once you have read and understood the above statement:

Name (print)_____ Date: _____

Signature_____

Due to HIPPA privacy regulations, your information will be held confidential and not shared with anyone.

If you are interested in receiving mailings about lectures, workshops, etc., please provide your mailing address, email, and phone number. Please fill out all areas that we may contact you.

Mailing Address (with Zip): _____

_____

Phone Number:_____ Email:_____

Referral Source:_____