

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](mailto: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
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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  $\checkmark$  any experiences below that you sometimes experience; two checks  $\checkmark\checkmark$  for those which occur often; and use three checks  $\checkmark\checkmark\checkmark$  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? \_\_\_\_\_

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Do you know what causes them? \_\_\_\_\_

## Common Physical Activities

- |  |   |
|--|---|
| <input type="checkbox"/> Desk Sitting (how long)     | <input type="checkbox"/> Standing (how long?) |
| <input type="checkbox"/> Sitting in a car (how Long) | <input type="checkbox"/> Jogging/Running      |
| <input type="checkbox"/> Calisthenics                | <input type="checkbox"/> Aerobics             |
| <input type="checkbox"/> Swimming                    | <input type="checkbox"/> Weight Lifting       |
| <input type="checkbox"/> Walking                     | <input type="checkbox"/> Yoga                 |
| <input type="checkbox"/> Tai Chi                     | <input type="checkbox"/> Hiking               |
| <input type="checkbox"/> Bike Riding                 | <input type="checkbox"/> Horseback Riding     |
| <input type="checkbox"/> Tennis                      | <input type="checkbox"/> BendingLifting       |
| <input type="checkbox"/> Other _____                 |   |

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):

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Red Meat        | <input type="checkbox"/> Butter      | <input type="checkbox"/> Candy bars/chocolate   |
| <input type="checkbox"/> Fish            | <input type="checkbox"/> Milk        | <input type="checkbox"/> Coffee                 |
| <input type="checkbox"/> Poultry         | <input type="checkbox"/> Cheese      | <input type="checkbox"/> Black Tea              |
| <input type="checkbox"/> Fruits          | <input type="checkbox"/> Yogurt      | <input type="checkbox"/> Herbal Tea             |
| <input type="checkbox"/> Vegetables      | <input type="checkbox"/> Sugar       | <input type="checkbox"/> Alcohol                |
| <input type="checkbox"/> Raw Foods       | <input type="checkbox"/> Honey       | <input type="checkbox"/> Vitamins               |
| <input type="checkbox"/> Grains          | <input type="checkbox"/> Baked Goods | <input type="checkbox"/> Protein Supplements    |
| <input type="checkbox"/> Nuts            | <input type="checkbox"/> Deserts     | <input type="checkbox"/> Food Supplements       |
| <input type="checkbox"/> Seeds           | <input type="checkbox"/> Chips       | <input type="checkbox"/> Processed foods/snacks |
| <input type="checkbox"/> Fermented Foods | <input type="checkbox"/> 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 used 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 your 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: \_\_\_\_\_