Trilogy Herbalism
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Herbal Consultation Intake Form

Please fill out this document to the best of your ability. **All information is kept Confidential.***

Name: _____
Date of Birth: ___/___/___
Age:____ Gender: _____
Email:_____ Phone:_____

What would you like the main focus of our session to be?

Do you prefer a focus on overall wellbeing or would like to focus on a body system (i.e digestion, nervous system)

What are your current physical complaints?

What is your previous medical history? Please mark two XX's if you've experienced a condition more than twice.
___ Acne ___ Autoimmune disorder ___ Kidney infections ___ Eczema ___ High blood pressure ___ Fainting spells/dizziness ___ Skin rashes ___ High cholesterol ___ Anxiety
___ Skin fungus ___ Heart conditions ___ Depression

___ Fatigue ___ Urinary tract infections ___ Emotional issues ___
Swollen lymph ___ Frequent colds/flus ___ Sinus issues
___ Cancer ___ Respiratory issues/infections/irritation ___ Ears/ Throat issues
___ Headaches ___ Anorexia/bulimia ___ Diabetes
___ Blood disorders ___ Anemia ___ Hormonal Imbalances ___ Thyroid
disorders

Please list any vitamin/mineral deficiencies:

Please list any previous medications and treatments:

_____

_____

_____ Please list any operations you have had and the date:

_____

_____

_____ Please list any major injuries/accidents, including date:

_____

_____

_____ Please list any traumatic experiences not treated medically (divorce, loss of job, death of loved one, etc) if you would like/feel safe to do so:

_____

Do you/have you suffered from emotional/mood/stress issues ? If so, do they come in conjunction with physical ailments?

What behaviors or habits do you engage in regularly that you believe support your health?

_____

_____

Please describe any current or past use of addictive or recreational substances:

_____

_____

Please list ALL current medications, supplements and herbs you are taking, how much, and how often.

Please list ALL allergies and sensitivities:

ENERGY

How are your energy levels in general?_____

What time(s) of day are your energy the highest? _____ lowest? _____

Have your energy levels changed at any point in the recent past?_____ If so, what preceded this change?_____ **SLEEP**

Do you have any difficulty falling asleep? _____

Staying asleep? _____ What time do you go to bed? _____

What time do you wake up? _____ Do you feel rested?_____Do you dream? _____If you wake in the middle of the night, how often do you wake? _____ What times of night do you wake? _____ What wakes you? _____

TEMPERATURE Do you run hot or cold? _____ What parts of your body feel the hottest/coldest? _____ What is your favorite temperature/ climate? _____ What part of the day are you warmest and coldest?

_____

DIET

How would you rate your appetite? ____ Ravenous ____ Strong ____ Average ____Weak ____Almost none ____ Fluctuates

List the types of foods you eat for a typical: Breakfast

_____

Lunch

_____

Dinner

_____

Snacks & Times eaten

_____

Fluids_____

_____

What foods do you crave?

_____

What are your favorite and least favorite foods and flavors?

_____

Do you have any known food allergies? No __ Yes __

List: _____

_____

Do you consume any of the following: Please indicate: s= sometimes, o= often, n=never _____ Soy products _____ Meat _____ Fish _____ Eggs _____ Dairy _____ Poultry _____ Beer _____ Wine _____ Coffee _____ Soda _____ Tea _____ Sugar _____ Candy _____ White Bread _____ Whole grain bread _____ Cold cereal _____ Whole grains or quinoa _____ Processed foods _____ Fast food _____ Fried Foods _____ Eating out at a restaurant _____ Raw veggies _____ Cooked veggies _____ Raw fruit _____ Dried or cooked fruit _____Butter _____ Margarine _____ Canola, soy or corn oils _____ Olive, coconut or palm oils _____ Organic produce and grains _____ Pastured/Grass-fed eggs, poultry, meat and dairy_____

Body Systems please rate as 1= sometimes 2= often 3= major concern or P = past condition. Leave blank if not applicable

DIGESTION: ____ Acid reflux ____ Diarrhea ____ IBS ____ Anorexia nervosa ____ Diverticulitis ____ Mouth Ulcers ____ Bad breath ____ Duodenal Ulcer ____ Parasites Polyps ____ Bloating ____ Flatulence ____ Polyps ____ Bulemia ____ Gallstones ____ Receding Gums ____ Constipation ____ Hemorrhoids ____ Stomach ulcer ____ Crohn's Disease ____ History of Hepatitis ____ Ulcerative colitis ____ Often forget to eat ____Strong appetite, eat regularly ____ Can skip meals easily ____ Anxious or faint if skip a meal ____Get irritable if skip a meal ____Tired/heavy after meal ____ Other:

_____

ELIMINATION: please indicate any usual qualities ____ Abdominal pain ____ Loose stool ____ Pale gray stool ____ Blood in stool ____ Food particles in stool ____ Pencil thin stool ____ Mucus in stool ____ Changes in bowel habits ____ Stool that floats ____ Painful defecation ____ Quick defecation after eating ____ Other: _____ How frequently do you have a bowel movement? _____

Describe the color, shape, & size of a typical BM _____

URINARY: ____ Bladder infections ____Painful urination ____ Cravings for salt ____ Kidney Stones ____ Lower back pain ____ Excessive fear/fearlessness ____ Water retention/edema ____ Dark circles under eyes ____ Frequent urge to urinate ____ Incontinence ____Gout ____ Wake up at night to urinate ____ Excessive Urination ____Frequent thirst ____ Incomplete emptying

Describe the frequency, color and smell of your urine

_____

RESPIRATORY: ____ Allergies/Hayfever ____ Difficulty breathing ____Wheezing ____ Asthma ____ Shortness of breath ____ Bronchitis ____ Cough ____ Fluid in lungs ____ Pleuritis ____ Postnasal drip ____ Recurrent influenza ____ Cold ____ Sinusitis ____ Runny

nose ____ Tuberculosis ____ Stuffy nose ____ Clear, thin mucus ____ Yellow/Green mucus ____ Dry, hard mucus ____ Easy to cough up mucus ____ Other: _____

CARDIO-VASCULAR: ____ High blood pressure ____ Low Blood Pressure ____ High cholesterol ____ Palpitations ____ Arteriosclerosis ____ Atherosclerosis ____ History of Heart attack ____ History of stoke ____ Congestive HeartFailure ____ Hands cold, clammy or dry ____ Hands warm, sweaty ____ Varicose Veins ____ Swelling in ankles/joints ____ Other: _____

IMMUNE/LYMPHATIC: ____ Arthritis (rheumatism) ____ Autoimmune disorders ____Fibromyalgia ____ Chronic fatigue ____ Neuralgia ____Frequently sick ____ Low-grade fever ____ Low white blood cell count ____ Injuries heal slowly ____ Swollen lymph glands ____ Mononucleosis ____ Lyme disease ____ Lymphatic congestion ____ Other: _____

SKIN: ____ Acne ____ Easily sunburned ____ Moles ____ Boils ____ Eczema and dermatitis ____ Rashes ____ Bleed or bruise easily ____ Psoriasis ____ Slow wound healing ____ Dry/itchy scalp or hair ____ red, burning or flushed skin ____Oily, damp scalp or hair___

MUSCULOSKELETAL: ____ Arthritis (not rheumatoid) ____ Mobility restriction ____ Sprains ____ Backache upper/lower ____ Broken bones ____ Tendonitis ____ Broken bones ____ Torn ligaments ____ Gout ____ Stiffness in joints ____ Bursitis ____ Other: _____

EARS, NOSE, THROAT: ____ Failing vision ____ Hearing loss ____ Tinnitus/ringing in ears ____ Ear aches ____ Ear infections ____ Sore or bleeding gums ____ Sore throat ____ Laryngitis ____ Frequent nosebleeds ____ Frequent stuffy nose ____ Difficulty swallowing ____ Other: _____

NERVOUS SYSTEM: ____ ADD/ADHD ____ Herpes or shingles outbreaks ____ Panic attacks ____ Anxiety ____ Depression ____Obsessiveness ____ Irritability ____Overwhelm ____ Numbness ____ Memory loss or changes ____ Mental fog ____ Stress ____ Headaches ____ Migraines ____ Insomnia

If you get headaches, can you describe the pain, location & triggers?

Which emotions do you experience most frequently? Please use o=often, s=sometimes, n=never

____ Anger ____ Joy ____ Sadness ____ Grief ____ Worry ____ Irritability ____ Fear ____ Melancholy ____ Restlessness ____ Lethargy

ENDOCRINE/METABOLISM: ____ Adrenal fatigue ____ Hypoglycemia ____ Elevated Blood Sugar ____ Diabetes (type I or II?) ____ Metabolic Syndrome ____ Hypothyroid ____

Hyperthyroid ____ Overweight, difficulty losing ____ Difficulty gaining weight ____ Pituitary ____ Pineal ____ Other: _____

REPRODUCTIVE MEN: Sexually transmitted disease; List type if known: _____ ____ Benign prostatic hypertrophy ____ Impotence ____ Painful ejaculation ____ Low sex drive ____ Low sperm count ____ Low sperm motility ____ Prostatitis ____ Difficulty with urination ____ Other: _____

REPRODUCTIVE WOMEN Pregnancies (dates): _____
Miscarriages (dates): _____ Abortions (dates): _____
Contraceptive use: List type and duration of use:

_____

_____

Sexually transmitted disease; List type if known:

_____

Hysterectomy (date):
_____Reason:_____ ____ Uterine Fibroids ____ Ovarian cysts ____ Endometriosis ____ Pelvic inflammatory disease ____ Cervical dysplasia ____ Infertility ____ Vaginal itching/discharge ____ Painful intercourse ____ Vaginal infection ____ Breast pain ____ Fibrocystic breasts ____ Lack of sex drive

Menstruating Women: ____ Absence of menstrual cycles ____ Irregular cycles ____Bleeding between cycles ____ Dramatic mood swings ____ Breast tenderness ____ Crave sugar before menses ____ Menses slow to start ____ Menses always lengthy ____Heavy bleeding ____ Painful menstrual cramps ____ Clots in menstrual blood ____ Anemia
Please elaborate on any inconsistencies or concerns you have about your cycle:
_____ **Menopausal Women**: ____ Dry vaginal lining ____ Hormone replacement therapy ____ Sore muscles ____ Hot flashes ____ Mood swings ____ Night sweats ____ Osteoporosis ____ Estrogen replacement therapy _____ Other: _____

_____

Please list family medical history:

Please use this space to describe anything else you feel is relevant to your current health concerns:

Thank you for filling out this Intake form! I look forward to helping you reach your wellness goals. * ☺