Land of Milk and Honey 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
___ Eczema
___ Skin rashes
___ Skin fungus
___ Fatigue
___ Swollen lymph
___ Cancer
___ Autoimmune disorder
___ High blood pressure
___ High cholesterol
___ Heart conditions
___ Urinary tract infections
___ Frequent colds/flus
___ Respiratory issues/infections/irritation
___ Kidney infections
___ Fainting spells/dizziness
___ Anxiety
___ Depression
___ Emotional issues
___ Sinus issues
___ 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. * ☺