



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/flu \_\_\_ 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:

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\_\_\_ Please list any operations you have had and the date:

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\_\_\_ Please list any major injuries/accidents, including date:

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\_\_\_ 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:

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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?

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

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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: \_\_\_\_\_

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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 \_\_\_\_\_ Bulimia \_\_\_\_\_ 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: \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 stroke \_\_\_\_ Congestive Heart Failure \_\_\_\_ 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. \* 😊