Banyan Moon Botanicals

College Station, TX

803.443.8246

www.banyanmoonbotanicals.com

kristin@banyanmoonbotanicals.com

Kristin Henningsen, M.S., C.H., R.Y.T.

**Herbal Consultation Client Intake Form**

**Name**

**Mailing Address**

**Phone**

**Email**

**Please Read: This is a rather long and intensive form; please feel welcome to answer only the questions you feel comfortable with. You may skip any portions that you feel are not relevant to you.**

How/when do you prefer to be contacted?

Age:

Birth date:

Gender:

Height:

Weight:

Occupation:

Referred by:

Reason for Visit:

Primary complaints and symptoms:

Other Problems:

Daily physical activity level (circle one): light /moderate /heavy

Daily / Weekly Exercise:

Are you currently under the care of a health care practitioner? Please note which of the following types of practitioners you have seen. Use “P” to indicate in the past and “C” to indicate if you are currently under their care.

\_\_\_ Medical Doctor

\_\_\_ Aromatherapist

\_\_\_ Ayurvedic Practitioner

\_\_\_ Chiropractor

\_\_\_ Counseling

\_\_\_ Herbalist

\_\_\_ Homeopath

\_\_\_ Naturopath

\_\_\_ Social Worker

\_\_\_ Massage Therapist

\_\_\_ Occupational Therapist

\_\_\_ Other Bodywork

\_\_\_ Physical Therapist

\_\_\_ Traditional Chinese Medicine Practitioner

\_\_\_ Traditional Thai Massage Therapist

\_\_\_ Other (Please indicate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Western Medical Diagnosis (if known):

Other Diagnosis:

List any current medications and treatments:

List any previous medications and treatments:

**Please check any of the below symptoms or diseases you have experienced. Use a scale of 1-5, 1 being infrequent to 5 being the most severe. If unsure, use a question mark ‘?’.**

\_\_\_\_Allergies

\_\_\_\_Headaches

\_\_\_\_Bloating

\_\_\_\_Sore throat

\_\_\_\_Too hot

\_\_\_\_Too cold

\_\_\_\_Excess stress

\_\_\_\_Anxiety

\_\_\_\_Fatigue

\_\_\_\_Sleep problems

\_\_\_\_Night sweats

\_\_\_\_Injuries

\_\_\_\_Seizures

\_\_\_\_Immune Disorders

\_\_\_\_Cancer

\_\_\_\_Gynecological problems

\_\_\_\_Menstrual irregularities

\_\_\_\_Urinary tract infections

\_\_\_\_Eyesight problems

\_\_\_\_Hearing problems

\_\_\_\_Shortness of breath

\_\_\_\_Rashes

\_\_\_\_Chemical sensitivities

\_\_\_\_Environmental sensitivities

\_\_\_\_High blood pressure

\_\_\_\_Low blood pressure

\_\_\_\_Stomach aches

\_\_\_\_Constipation

\_\_\_\_Heart disease

\_\_\_\_Tumors

\_\_\_\_Male health problems

\_\_\_\_Memory loss

\_\_\_\_Painful joints

\_\_\_\_Arthritis

\_\_\_\_Stiffness

\_\_\_\_Asthma

\_\_\_\_Dizziness

\_\_\_\_Sore throats

\_\_\_\_Alcoholism

\_\_\_\_Drug abuse

\_\_\_\_Diabetes

\_\_\_\_Numbness

\_\_\_\_Diarrhea

\_\_\_\_Respiratory problems

\_\_\_\_Chronic fatigue

\_\_\_\_Common cold

**Childhood diseases and syndromes**

Please check any pertinent to you

\_\_\_\_Chicken pox

\_\_\_\_Measles

\_\_\_\_German measles (Rubella)

\_\_\_\_Rheumatic fever

\_\_\_\_Asthma

\_\_\_\_Allergies

\_\_\_\_Atopic eczema

\_\_\_\_Tonsilitis

\_\_\_\_ADD

\_\_\_\_Bronchitis

\_\_\_\_Mononucleosis

\_\_\_\_Whooping cough (Pertussis)

\_\_\_\_Mumps

\_\_\_\_Learning disabilities

**Skin**

Mark any of the conditions below that pertain to you. Use ‘P’ for past problem and ‘C’ for current.

\_\_\_\_Bruise easily

\_\_\_\_Dry hair

\_\_\_\_Dry skin

\_\_\_\_Eczema/psoriasis

\_\_\_\_Hair loss

\_\_\_\_Itchy

\_\_\_\_Oily hair

\_\_\_\_Oily skin

\_\_\_\_Pimples

\_\_\_\_Rashes

\_\_\_\_Scars

\_\_\_\_Sensitive to chemicals

\_\_\_\_Sensitive to touch

\_\_\_\_Skin tags

\_\_\_\_Slow to heal

\_\_\_\_Varicose veins

**Energy Levels**

Time of day you feel most tired?

Time of day you feel most awake?

Are you satisfied with your energy level?

Have you noticed your energy levels change dramatically at any point recently or in your past?

If yes, please describe:

**Hospitalization**

Were you ever hospitalized?

Reason:

Treatment:

Please list any surgeries you have had with approximate dates and reasons for them:

**Injuries**

Have you had any severe injuries?

What therapies did you use for them?

Have you ever had broken bones?

Have you ever been in an accident? If yes, please describe

Have you ever injured your spine or back?

**Family History**

Any history of illness in your family?

Has anyone in your family had any of the following?

\_\_\_ Cancer

\_\_\_ Diabetes

\_\_\_ Heart Disease

\_\_\_ High Blood Pressure

\_\_\_ Low Blood Pressure

**Allergies**

Do you have any allergies?

Caused By?

Have or do you take any medicine for them?

When and where are your allergies least and most troublesome?

Are you allergic to any drugs (including herbal medicines)?

What has helped your allergies most?

**Diet**

Please fill in the below chart using the following scale.

O – Do not consume this

D – Consume this once a day

FD – Consume this a few times daily

W – Consume this approximately once a week

FW – Consume this a few times weekly

M – Consume this approximately once a month

\_\_\_\_Vegetables cooked

\_\_\_\_Vegetables raw

\_\_\_\_Vegetables canned

\_\_\_\_Fruit – fresh or frozen

\_\_\_\_Fruit – canned

\_\_\_\_Fried foods

\_\_\_\_Beef

\_\_\_\_Chicken

\_\_\_\_Pork

\_\_\_\_Fish

\_\_\_\_Other meat (Indicate)

\_\_\_\_Seafood

\_\_\_\_Seaweed

\_\_\_\_Sweets

\_\_\_\_Potato chips

\_\_\_\_Tortilla chips

\_\_\_\_Eggs

\_\_\_\_Milk

\_\_\_\_Cheese

\_\_\_\_Pizza

\_\_\_\_Refined sugar

\_\_\_\_Unrefined sugar

\_\_\_\_Baked goods

\_\_\_\_Bread Products

\_\_\_\_Refined flour

\_\_\_\_Whole grains

\_\_\_\_Organic foods

\_\_\_\_Black tea

\_\_\_\_Green tea

\_\_\_\_Coffee

\_\_\_\_Herbal tea

\_\_\_\_Fruit Juice

\_\_\_\_Vegetable Juice

\_\_\_\_Water

\_\_\_\_Soda

\_\_\_\_Eat out

\_\_\_\_Fast food

\_\_\_\_Fasting

\_\_\_\_Nuts/seeds

\_\_\_\_Peanut butter

\_\_\_\_Nut butters

\_\_\_\_Fermented foods

\_\_\_\_Diet soda

\_\_\_\_Sweet & Low, Equal or other Sugar

Replacement

Describe your eating habits. Give examples of daily food intake.

Breakfast:

Lunch:

Dinner:

Snacks:

Cravings (Circle all that apply) Sour Sweet Salty Oily Bitter Bland

Describe your caffeine/nicotine/alcohol/drug intake

Please indicate any diets you are currently on or previously have been on:

**Digestion**

Please use ‘P’ for previously, ‘C’ for currently or ‘?’ for unsure.

\_\_\_\_Anorexia nervosa

\_\_\_\_Belching

\_\_\_\_Bulimia

\_\_\_\_Changes in bowel habits

\_\_\_\_Constipation

\_\_\_\_Diarrhea

\_\_\_\_Diverticulitis

\_\_\_\_Eating disorders

\_\_\_\_Flatulence

\_\_\_\_Food is unappetizing

\_\_\_\_Gallstones

\_\_\_\_Heartburn

\_\_\_\_Hemorrhoids

\_\_\_\_Indigestion

\_\_\_\_Irritable Bowel Syndrome

\_\_\_\_Lactose Intolerance

\_\_\_\_Large appetite

\_\_\_\_Liver problems

\_\_\_\_Low appetite

\_\_\_\_Nausea

\_\_\_\_Pain after eating

\_\_\_\_Parasites

\_\_\_\_Scanty appetite

\_\_\_\_Soy Intolerance

\_\_\_\_Stomach aches

\_\_\_\_Sudden weight change

\_\_\_\_Trouble digesting carbohydrates

\_\_\_\_Trouble digesting fats

\_\_\_\_Trouble digesting proteins

\_\_\_\_Ulcer

\_\_\_\_Ulcerative colitis

\_\_\_\_Vomiting

\_\_\_\_Wheat / Gluten Allergy

**Body Temperature**

Please write ‘H’ for Hot and ‘C’ for Cold, if applicable to these body areas

\_\_\_\_General body

\_\_\_\_Arms

\_\_\_\_Hands

\_\_\_\_Palms

\_\_\_\_Fingers

\_\_\_\_Legs

\_\_\_\_Feet

\_\_\_\_Head

\_\_\_\_Back

\_\_\_\_Chest

\_\_\_\_Stomach

You tend to enjoy (circle one) hot cold weather

Best time of year (circle all that apply) spring summer fall winter

What part of the day are you the warmest?

What part of the day are you the coldest?

Do you sweat easily?

**Emotional State**

Use a scale of 1 (rare) to 5 (very common) on the below conditions that are pertinent to you.

\_\_\_\_Happy

\_\_\_\_Enthusiastic

\_\_\_\_Inspired

\_\_\_\_Sad

\_\_\_\_Depressed

\_\_\_\_Lethargic

\_\_\_\_Manic

\_\_\_\_Bi-polar

\_\_\_\_Anxious

\_\_\_\_Forgetful

\_\_\_\_Attentive

\_\_\_\_Grumpy

\_\_\_\_Fearful

\_\_\_\_Angry

\_\_\_\_Nervous

\_\_\_\_Worry

\_\_\_\_Think a lot

**Memory**

How is your long-term memory?

How is your short-term memory?

Has your memory changed noticeably in the past few years?

**Eyesight**

How would you describe your vision?

Are you near or far sighted?

Do you wear glasses or contact lenses?

At what age did you begin wearing them?

Does the prescription of your glasses change often?

**Ears**

How is your hearing?

Has it changed in the past years?

Have you previously had (P) or currently have (C)

\_\_\_\_Earaches

\_\_\_\_Hearing loss

\_\_\_\_Tinnitus/Ringing

\_\_\_\_Overly sensitive

\_\_\_\_Ear infections

\_\_\_\_Wax build-up

**Mouth & Throat**

Please list ‘P’ for previous or ‘C’ for current conditions

\_\_\_\_Sore gums

\_\_\_\_Mouth sores

\_\_\_\_Lip sores

\_\_\_\_Constant dryness

\_\_\_\_Difficult to swallow

\_\_\_\_Excess saliva

\_\_\_\_Painful/tight jaw

\_\_\_\_Multiple cavities

\_\_\_\_Loose teeth

\_\_\_\_Oral herpes

\_\_\_\_Sore throats

\_\_\_\_Swollen glands

\_\_\_\_Swollen tongue

**Headaches**

Do you ever have headaches?

How often?

Location/type of headaches

\_\_\_\_Migraine

\_\_\_\_Chronic

\_\_\_\_Cluster

\_\_\_\_Morning

\_\_\_\_Afternoon

\_\_\_\_Evening

\_\_\_\_Night

\_\_\_\_After eating

\_\_\_\_Before eating

\_\_\_\_Around eyes

\_\_\_\_Band around head

\_\_\_\_Back of head

\_\_\_\_Base of neck

\_\_\_\_Around temples

\_\_\_\_Left side

\_\_\_\_Right side

\_\_\_\_Sharp

\_\_\_\_Dull

\_\_\_\_Throbbing

\_\_\_\_Pounding

\_\_\_\_Light but constant

Are they seasonal? If so, which season?

After a bowel movement, do they get better or worse?

Other symptoms and troubles associated with the headache?

Are they more or less often than in the past?

Are they related to your menstrual cycle? Before, During or After (Circle One)

How long have you had them?

Does the severity or intensity vary from episode to episode?

What medicines and treatments have you tried?

Which medicines and treatments were the most successful?

Do you have any ideas on what triggers them?

**Urinary Tract**

Please mark ‘P’ for previous and ‘C’ for current for any of the below conditions

\_\_\_\_Bloating

\_\_\_\_Blood in urine

\_\_\_\_Burning urination

\_\_\_\_Frequent urges to urinate

\_\_\_\_Kidney/Bladder stones

\_\_\_\_Lower back pain

\_\_\_\_Pain around Kidneys

\_\_\_\_Strong smelling urine

\_\_\_\_Urinary tract infections

\_\_\_\_Water retention

Approximately how many times a day do you urinate?

Do you wake up at night to urinate? If Yes, How many times

Is it ever hard to urinate?

When you have the need to urinate, does it feel urgent?

Have you had urinary tract infections? If Yes, how often?

How did you treat it?

**Bowel Movements**

How many times a day do you defecate?

Is it ever difficult to defecate?

Do your feces tend toward loose (soft) or hard?

Are you ever constipated (not defecating for more than one day in a row)?

Do you ever have diarrhea (constant very loose stools)?

Is your urge to defecate urgent?

Do you wake up at night or very early morning to defecate?

Does it ever hurt to defecate?

Are your stools very strong smelling often?

Do you strain to defecate?

Other bowel problems or symptoms

**Reproductive – Male**

Use ‘P’ for past condition, ‘C’ for current, ‘S’ for unsure or ‘?’ for any questions.

\_\_\_\_Frequent urination

\_\_\_\_Difficulty getting urine flowing

\_\_\_\_Painful to urinate

\_\_\_\_Interrupted flow of urine

\_\_\_\_Erectile dysfunction

\_\_\_\_Impotence

\_\_\_\_Low vitality

\_\_\_\_Benign Prostatic Hyperplasia (BPH)

\_\_\_\_Prostate pain

\_\_\_\_Penis pain

\_\_\_\_Testicle pain

\_\_\_\_Painful ejaculation

\_\_\_\_Blood in urine

\_\_\_\_Blood in semen

**Other**

How often do you get up at night to urinate?

Do you need to urinate frequently? Approximately how often?

Do you drink coffee, black or green tea, or soda?

Does your prostate region ever hurt?

If yes, is pain dull, constant, throbbing or sharp; while sitting, or standing (circle)

Is it ever difficult to get your urine flowing?

Is it ever painful to urinate – describe the pain?

Does the urge to urinate interfere with your daily activities?

Do you have any problems getting and/or maintaining an erection?

Are you satisfied with your sexual vitality?

Do you have any health concerns about your sexuality or vitality?

**Reproductive – Female**

Use ‘P’ for past condition, ‘C’ for current, ‘S’ for unsure or ‘?’ for any questions.

*General*

\_\_\_\_Breast pain

\_\_\_\_Endometriosis

\_\_\_\_Cervical dysplasia

\_\_\_\_Fibroids

\_\_\_\_Unusual PAP

\_\_\_\_Painful intercourse

\_\_\_\_Vaginal dryness

\_\_\_\_Vaginal discharge

*Menstrual Cycle*

\_\_\_\_Bleeding between cycles

\_\_\_\_Mood swings

\_\_\_\_Bloating (hands, stomach)

\_\_\_\_Bloating (feet, hands, ankles)

\_\_\_\_Irregular cycle

\_\_\_\_Painful menses

Does your blood tend to be?

\_\_\_\_Bright red

\_\_\_\_Red

\_\_\_\_Red brown

\_\_\_\_Dark colored

\_\_\_\_Clots

*Menopause*

\_\_\_\_Hot flashes

\_\_\_\_Night sweats

\_\_\_\_Hormone replacement therapy

\_\_\_\_Mood swings

\_\_\_\_Other changes

*Contraception Method*

\_\_\_\_Birth control pills

\_\_\_\_IUD

\_\_\_\_Diaphragm

\_\_\_\_Rhythm

\_\_\_\_Mucus testing

\_\_\_\_Cycle Beads™

\_\_\_\_Other (please explain)

Other

\_\_\_\_Vaginal infection

\_\_\_\_Pelvic inflammatory disease (PID)

\_\_\_\_Tumors

\_\_\_\_Infertility

\_\_\_\_STDs

\_\_\_\_Miscarriage

\_\_\_\_Ovarian or other cysts

Menses cycle >28 days

(Approx # of days\_\_\_\_\_\_\_)

Menses cycle <28 days

(Approx # of days\_\_\_\_\_\_\_)

Do you have pre-menses diarrhea/constipation?

Average # of days bleeding\_\_\_\_\_\_\_

\_\_\_\_Profuse flow

\_\_\_\_Slow flowing

\_\_\_\_Scanty flow

\_\_\_\_Heavy flow

\_\_\_\_Dry vaginal mucosa

\_\_\_\_Osteoporosis

\_\_\_\_Fibromyalgia

**Immune System**

Please mark 0 for never, 1 for sometimes, 2 for almost always

\_\_\_\_Allergies

\_\_\_\_Autoimmune disorders

\_\_\_\_Cancer

\_\_\_\_Chronic diarrhea

\_\_\_\_Chronic fatigue

\_\_\_\_Chronic sore throats

\_\_\_\_Chronically sick

\_\_\_\_Heal slowly

\_\_\_\_Low grade fever

\_\_\_\_Lowered resistance

\_\_\_\_Recurring infections

\_\_\_\_Swollen lymph glands

Other comments on your immunity?

**Sleep Patterns**

On a scale from 1 (rarely) to 5 (very often) mark the conditions pertinent to you.

\_\_\_\_Fall asleep fast

\_\_\_\_Sleep through the night

\_\_\_\_Hard to fall asleep, but stay asleep throughout the night

\_\_\_\_Hard to fall and stay asleep

\_\_\_\_Wake often

\_\_\_\_Wake up to urinate

\_\_\_\_Restless sleep

\_\_\_\_Restful sleep

\_\_\_\_Hard to wake up in the morning

\_\_\_\_Stay awake till 11:00pm

\_\_\_\_Stay awake till 1:00am

\_\_\_\_Stay awake till 3:00am

Dreams (circle those that apply): active, lucid, anxious, nightmares, probing, pleasant, sexual, interesting, scary, other (describe\_\_\_\_\_\_\_\_\_\_\_\_\_)

Which are your favorite hours to sleep?

Generally, how many hours of sleep do you need to feel rested?

What time do you generally get up in the morning?

Do you feel you are getting the sleep you need?

**Cardiovascular Health**

If known, what is your:

Resting pulse rate Blood pressure (avg) Cholesterol level:

Does your blood pressure fluctuate much?

Do you or have you taken any heart medicines, including herbs, drugs or others?

What are they?

Do you ever feel tight pains in your chest?

When have they occurred?

**Please check the below questions pertinent to your health**

\_\_\_\_Angina

\_\_\_\_Arrhythmias (irregular heart beat)

\_\_\_\_Arteriosclerosis

\_\_\_\_Black and blue easily

\_\_\_\_Bleed easily

\_\_\_\_Capillary fragility

(blood vessels rupture easily)

\_\_\_\_Cardiac arrest

\_\_\_\_Chest pains

\_\_\_\_Congenital deformities

\_\_\_\_Congestive heart failure

\_\_\_\_Edema (swollen with water)

\_\_\_\_Fast heart beat (tachycardia)

\_\_\_\_Heart attack

(myocardial infarction)

\_\_\_\_Heart flutter/fibrillation

\_\_\_\_Heart murmur

\_\_\_\_High blood pressure

\_\_\_\_Low blood pressure

\_\_\_\_Mitral valve prolapse

\_\_\_\_Palpitation

\_\_\_\_Poor circulation

\_\_\_\_Rheumatic fever

\_\_\_\_Slow heart beat (bradycardia)

\_\_\_\_Stroke

\_\_\_\_Varicose veins

**Nervous System and Stress**

Please mark with ‘P’ for previously and ‘C’ currently to any conditions that are pertinent to you.

Please also follow a scale of 1 (not frequent) to 5 (chronic).

\_\_\_\_Anxiousness

\_\_\_\_Nervous stomach

\_\_\_\_Trouble falling asleep

\_\_\_\_Cannot stay asleep

\_\_\_\_Constant feeling of stress

\_\_\_\_Difficult to grasp small objects

\_\_\_\_Diminished taste

\_\_\_\_Fear of known

\_\_\_\_Fear of unknown

\_\_\_\_Fluctuating vision

\_\_\_\_Hard to concentrate

\_\_\_\_Involuntary spasms

\_\_\_\_Memory loss

\_\_\_\_Nervous to answer the phone

\_\_\_\_Nervousness

\_\_\_\_Numbness

\_\_\_\_Pain – constant

\_\_\_\_Pain – moves around body

\_\_\_\_Pain – sudden and soon gone

\_\_\_\_Panic attacks

\_\_\_\_Seasonal affective disorder (S.A.D)

\_\_\_\_Sudden changes in body temperature

\_\_\_\_Sudden mood swings

\_\_\_\_Twitching/Shaking

\_\_\_\_Worsening coordination

\_\_\_\_Work related stress level high

**Respiratory**

Do you have much congestion?

Is the quality and/or color of the mucous:

\_\_\_\_clear

\_\_\_\_yellow

\_\_\_\_green

\_\_\_\_thin/runny

\_\_\_\_medium

worse in the:

morning, afternoon,evening, night (circle one )

other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which season brings the most congestion?

Have you identified foods, environmental factors, situations which worsen your breathing (i.e.

with mucous/congestion or tightness)? What are they?

Have you ever used a Neti Pot?

**Coughing**

Check the symptoms which pertain to you

\_\_\_\_frequently

\_\_\_\_persistent

\_\_\_\_dry cough

\_\_\_\_wet cough

\_\_\_\_abrupt onset

\_\_\_\_itchy at back of throat

\_\_\_\_once started, hard to stop

\_\_\_\_painful

\_\_\_\_bring up blood

\_\_\_\_infrequently,

\_\_\_\_worse at morning,

\_\_\_\_hacking

What triggers your coughing?

Is it related to any other troubles in your body (i.e. headaches, stiff joints, etc)?

Which seasons are worse?

Do you frequently have a cold or the flu?

Please mark with a ‘P’ for previously a problem, ‘C’ for currently so, and ‘?’ if unsure.

\_\_\_\_Asthma

\_\_\_\_Bronchitis

\_\_\_\_Chest pain

\_\_\_\_Common cold

\_\_\_\_Coughing

\_\_\_\_Difficulty smelling

\_\_\_\_Flu

\_\_\_\_Fluid in lungs

\_\_\_\_Hay fever

\_\_\_\_Inflammation of lungs or bronchi

\_\_\_\_Laryngitis

\_\_\_\_Runny nose

\_\_\_\_Shortness of breath

\_\_\_\_Sneezing

\_\_\_\_Stuffy nose

\_\_\_\_Tight feeling in chest

\_\_\_\_Trouble breathing

\_\_\_\_Wheezing

**Additional Questions & Notes**

By filling out this questionnaire you are providing information to be used by Kristin Henningsen to assist you in creating a holistic lifestyle program. This information will not be used by any third party for any reason and will be kept strictly confidential. The questionnaire and follow-up consultation are not meant to substitute for a primary medical diagnosis or seeing a primary care physician or for treating, a serious or life-threatening conditions that should be seen by a qualified primary care medical doctor.

I have read & understand the above,

Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclaimer: This information is provided for educational purposes and is not intended as and must not be taken as a diagnosis for any disease.**