Name:	**Date:**	**Date of Birth:**	
Current Gender Identity:	**Sex Assigned at Birth:**	**Age at First Menstruation:**	
Average Cycle Length:	**Length of Bleeding:**	**Cycle: Regular / Irregular**	**Currently Pregnant? Y / N**
Number of previous pregnancies:	**Number of live births:**	**Ages of Children:**	

Why are you seeking herbal consultation?

Circle symptoms that regularly occur during menstruation:

Heavy Cramping Heavy Bleeding Migraines Irritability Vomiting Back Pain Mood Swings Spotting

List any current health issues or diagnoses:

Current Medications, Supplements, Vitamins, Herbs:

Average Hours of Sleep:	**Circle your symptoms: Trouble falling asleep Trouble staying asleep Early waking**

List current stressors:

If you are two years or less postpartum, circle your symptoms:

Depression Lack of interest in normal activities Anxiety Irritability Extreme Fatigue Low energy Mood Swings

Irregular periods Insomnia

Currently Breastfeeding: Y / N	**Regular Bowel Movements: Y / N**	**Typical Stool Type:**

Do you experience any of the following:

Low libido Depression Anxiety Unexplained weight gain Frequent illness GI discomfort

Have you been diagnosed with any of the following:

Diabetes Auto immune disease Endometriosis PCOS Depression Anxiety Bipolar IBS

List the food and drink you have consumed in the last 24 hours:

List any dietary restrictions or food sensitivities/allergies?

Comments (any other medical or personal history):