

## **Informed Consent and Client Responsibility**

Moon Root Medicinals

Tessa Micaela Landreau-Grasmuck, clinical herbalist

The purpose of this form is to outline the responsibilities of the client and the practitioner as they enter into a healing partnership. It is provided to clarify the client/practitioner relationship and to outline the standards of practice of an herbal consultant. My hope is that with this information, you can make an informed choice about whether or not you wish to consult with me, Tessa Micaela Landreau-Grasmuck, and, if so, what you want to learn and achieve through your work with me.

### **The Role of the Herbal Practitioner**

I believe the herbalist's primary role is as an educator and partner, encouraging and supporting your goals for improved health and well-being. Herbalists do not diagnose, cure or directly treat disease. Rather, we focus on educating you, the client, on how to best enhance your body's innate healing capacity. Our intent is to help you achieve the most balanced state of health consistent with your own goals and in alignment with your body's knowing and autonomy. In contrast with conventional medical care, which is primarily designed to compensate for what the body is not doing for itself, herbal "medicine" is adaptive, based on the belief that the human body is a resilient and intelligent system that has the capacity for self-healing. I believe that properly crafted herbal formulas assist and encourage the body in its effort to return to a state of balance. Every person's state of balance is unique, because every person is physiologically, emotionally and energetically unique. I will consider your individual constitution and nature and recommend the most appropriate herbal, dietary and lifestyle changes crafted specifically for you.

### **Client Rights and Responsibilities**

All client records are confidential. I hold in strict confidence all information gathered and discussed with you, unless you specifically request otherwise. I will answer any questions regarding practitioner training, credentials and scope of practice. If I feel that your needs and desires are beyond the scope of herbal practice or my expertise, you will be referred to another practitioner. I support and encourage your right to consult any practitioner of your choice, especially in the diagnosis and treatment of disease.

Payment is due at the time services are rendered. You may purchase herbs and herbal products from me, however you are not obligated to do so and may purchase herbs wherever you wish. (Or make your own!) You are free to refuse to follow any of the recommendations provided as a result of your consultation and/or to choose to discontinue the client/practitioner relationship at any time.

Moon Root Medicinals is committed to accessible, culturally responsive and appropriate care. All people, regardless of race, color, religious or spiritual belief, cultural background, sexual orientation, gender identification or available economic resources are welcome. You can, and should, expect a respectful, courteous, and caring experience. I welcome any feedback you may have regarding any and all aspects of your experience with me as your herbalist. You deserve to be in the care of the practitioner or healer who is right for you, when they are right for you, and I can recommend other practitioners if you don't think I'm the herbalist for you. You are (of course) free to refuse to follow any of the recommendations provided as a result of your consultation and/or to choose to discontinue the client/practitioner relationship, and if you decide to do so, I appreciate you making me aware of this decision.

**If you need to cancel an appointment, please give no less than 24 hours notice. Except in cases of emergency, of no notice is given, you will be charged a \$50 cancellation fee.**

### **Side Effects, Toxicity, and Herb-Drug Interactions**

Historical evidence and modern research indicate that the most commonly used herbs have an exceptional safety record. Similarly, confirmed cases of herb and drug interactions are rare. However, adverse events can occur after using any active substance. I will not suggest that clients ingest plant doses known to have toxic effects. The organs that are most vulnerable to any potent substances are the liver and kidneys, and it is important for you to divulge any previous history of disease in either of these organs so that I can provide you with information suitable to your circumstances. Herbs also should not be used in pregnancy or lactation without expert advice, and if you become pregnant you should stop taking herbs until advice is received either from your herbalist or another knowledgeable professional. It is your responsibility to fully disclose any medications currently in use, including other herbs and supplements, so that you can be offered informed advice. It is also recommended that you inform your doctor of all herbal and nutritional supplements you are taking. Any suggestion that the effect of a drug is being altered by simultaneous use of an herb should be reported directly to all health professionals involved. It is also advisable to stop taking herbs at least 48 hours before a surgical operation, and in the event of being prescribed anticoagulants, antiepileptic drugs, and digoxin.

### **Acknowledgement**

I \_\_\_\_\_, have read this document and I understand the nature and extent of the client and practitioner relationship. I hereby voluntarily consent to an herbal consultation. I understand that I am free to discontinue service at any time. I understand that my practitioner is not a licensed physician and therefore cannot diagnose or treat disease, or prescribe drugs. I understand that an herbal consultation is not a substitute for regular medical care, but can offer guidance and information so that I may better understand and heal myself.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(adapted from the Vermont Center for Integrative Herbalism)

**Moon Root Medicinals  
New Client Intake Form**

Please complete this form prior as thoroughly as possible, to assist in clinical assessment. Please fill it out before our first meeting, if at all possible, and email to Tessa. It should take 30-45 minutes to complete, and you're welcome to skip questions you'd prefer not to answer. Thank you!

**Name:**

**Today's Date:**

**Birthdate:**

**Age:**

**Gender and pronoun:**

**Telephone:**

**Email:**

**Address:**

**City/State/Zip:**

**Occupation/work:**

**Hours per week:**

**What are your primary goals/concerns in working with an herbalist? (Why did you schedule an appointment?)**

1.

2.

3.

**What health related issues do you have / have you had in the past? How long has it been going on?**

**Primary Care Provider (please include contact information):**

**Please list any other practitioners you are currently working with:**

**Current Medications (over the counter and prescription)**

	Dosage/Frequency	Reason?

*Please feel free to attach a separate list or continue on the back if you are taking more medications than there is space for.*

**Current supplements / herbs / vitamins**

Supplement (including brand)	Dosage/Frequency	Reason?

**Have you had any prolonged use of any medication in the past? What & for how long?**

Allergies to any medications:

Reaction:

Food, environmental, seasonal or other allergies? Please describe, including the substances to which you are allergic and any symptoms you experience.

**Medical History**

Please indicate any health conditions that you've experienced and/or that a provider has diagnosed and provide the date of onset. Circle those you currently experience, and underling those for past conditions.

**Gastrointestinal**

Celiac Disease    Crohn's Disease    Gastric or peptic ulcer    GERD/heartburn/reflux    Irritable Bowel Syndrome    Liver Disease    Small Intestinal Bacterial Overgrowth (SIBO)  
 Ulcerative Colitis    Excessive Gas/Bloating

Other Gastrointestinal conditions: Indicate whether past or current & include date of onset.

**Respiratory**

Asthma    Bronchitis    Chronic Sinusitis    COPD    Emphysema    Pneumonia  
 Sleep Apnea    Tuberculosis

Other Respiratory conditions: Indicate whether past or current & include date of onset.

Musculoskeletal/Pain/Autoimmune

Chronic Fatigue Syndrome    Epstein-Barr Virus    Fibromyalgia    Graves Disease    Gout  
Hashimoto's Thyroiditis    Herpes    Lupus/SLE    Lyme Disease    Migraines  
Non-Migraine Headache    Osteoarthritis    Rheumatoid Arthritis

Other Inflammatory/Autoimmune conditions: Indicate whether past or current & include date of onset

Neurological and Mental Health

ADD/ADHD    Addiction or Substance Abuse    Alzheimer's Disease    ALS    Anorexia    Anxiety  
Asperger's/Autism    Bulimia    Depression    Other Eating Disorder  
Parkinson's Disease    Seizures    Stroke    Suicidal thoughts or ideation

Other Neurological/Mental Health conditions: Indicate whether past or current & include date of onset.

Blood/Cardiovascular Health

Anemia    Atherosclerosis    Beta-thalassemia    Elevated Cholesterol  
Heart Attack/MI    High Blood Pressure    Irregular Heart Beat    Low Blood Pressure  
Mitral Valve Prolapse

Other Cardiovascular conditions Indicate whether past or current & include date of onset

Cancer: Please indicate kind, past or current & date of onset

Metabolic/Endocrine

Diabetes, Type I    Diabetes, Type II    Hypoglycemia  
Hypothyroidism/Hashimoto's Thyroiditis    Hyperthyroidism/Graves' Disease  
Metabolic Syndrome (pre-diabetes, insulin resistance)    Polycystic Ovarian Syndrome

Other Metabolic/Endocrine conditions Indicate whether past or current & include date of onset.

Dermatological

Acne    Eczema/Atopic    Dermatitis    Psoriasis    Rosacea    Rash

Other Dermatological conditions Indicate whether past or current & include date of onset.

Urinary/Generative Health

Endometriosis    Erectile Dysfunction    Infertility    Kidney Stones    PCOS  
Pregnancy Loss    Problems with sperm count, motility, morphology    Prostate Problems  
Uterine Fibroids    Urinary Tract Infection    Yeast Infection

Sexual Health:

Do you experience any of the following?

Low libido    Pain with sex    Difficulty reaching orgasm    Vaginal dryness

Menstruation, Pregnancy, and Lactation History

Is this section relevant for you?

Circle yes if you currently menstruate or used to menstruate.    Yes    No

Date of last menstrual period? (Note the first day of heavy bleeding during your last menstrual cycle.)

Are you ovulating regularly? How do you know?

How many days pass between your menstrual cycles? (Start from the first day of heavy bleeding and count until the first day of heavy bleeding in the following cycle.)

How many days of bleeding do you experience each cycle? P

lease also note if you experience bleeding in between cycles and which days.

Do you experience any of the following related to your menstrual cycle?

Heavy bleeding/clotting    Mood changes    PMS or PMDD  
Irregular or infrequent cycles    Spotting    Cramping    Food cravings  
Changes in bowel movements

Would you consider your flow on your heaviest day to be:

Extremely heavy      Heavy      Medium      Light      Very light      Not sure

Are you now or have you ever been pregnant?

Pregnancies: Include live births, losses, terminations if you are comfortable doing so

Date      Outcome (vaginal/c-sec, loss, termination)      Notes

Currently lactating?

If not, are you actively trying to conceive?

How long have you been trying?

What type(s) of birth control are you using (if relevant)?

Are you currently peri- or post-menopausal?      Yes      No

When was your last menstrual cycle?

Do you experience any of the following symptoms?

Hot flashes/night sweats      Changes in mood      Vaginal dryness      Weight gain

Cognitive changes (forgetfulness, etc)      Hair loss or thinning

Other Urinary/Generative/reproductive conditions Indicate whether past or current & include date of onset.

**\*\*If you discover that you are newly pregnant during our work together, please discontinue all herbs until we can discuss whether your recommendations need to be modified\*\***

Birth History and Childhood Health

Your birth: Vaginal C-Section Unknown

Were you breast/chest fed? Formula fed? Unknown?

For how long?

How would you rate your health as a child?

Excellent Good Fair Poor

Please describe any health challenges or significant experiences from childhood.

### Family Health History

*Alive/Deceased*

*Present health or cause of death*

Parents:

Brother(s):

Sister(s):

Children: (ages):

**Have any blood relatives had the following?**

Please circle from the following list:

- |                            |                     |                 |
|----------------------------|---------------------|-----------------|
| Allergy/Asthma             | Headaches/Migraines |                 |
| Arthritis                  | Heart Disease       | Stroke          |
| Bleeding/Clotting Disorder | High Blood Pressure | Substance Abuse |
| Cancer: (type)             | Kidney Disease      | Thyroid Disease |
| Diabetes                   | Liver Disease       | Tuberculosis    |

**Diet: Please indicate how frequently you consume any of the following:  
(daily, weekly, monthly)**

- |                        |              |                |
|------------------------|--------------|----------------|
| Dairy                  | Beans        | Eggs           |
| Soft Drinks            | Soy products | Fried Foods    |
| Margarine              | Fish         | Butter         |
| Chicken/Turkey         | Nuts/Seeds   | Vegetables     |
| Coffee                 | Fruits       | Red Meats      |
| Greens (Kale/Collards) | Baked Goods  | Chips/Crackers |

**Please indicate an example of (1) what you eat when you have time and energy and (2) what you eat diet when stressed or pressed for time. Please include times you eat.**

- (1) Typical Breakfast/Lunch/Dinner/Snack/Beverages with time and energy
- (2) Typical Breakfast/Lunch/Dinner/Snack/Beverages when stressed or pressed for time

List any foods you are allergic to or sensitive to:

How many meals do you eat a day? \_\_\_\_\_

How often do you snack and when? \_\_\_\_\_

How often do you eat while driving/working/multitasking?

How often do you eat at restaurants?

How often do you cook/prepare food?

Any foods that you regularly crave?

Do you ever follow or have you followed a restricted diet? which one(s)?

Is there anything you'd like me to know about your relationship to food or eating?

How much alcohol do you consume in a week?

How much tobacco?

Do you do use cannabis? How often?

Do you do or have you done other kinds of drugs? How often?

**General Health Questions:**

What things bring you joy? What are your passions and interests?

Current Work: How long?

Previous Occupations:

Please describe your home/living situation:

Please list any surgeries or hospitalizations and what year they occurred. Describe any complications.

Any known exposure to environmental toxins in your lifetime? (polluted neighborhood, work w/toxins?)

Typical hours per day watching TV: On the computer:

What kind of exercise or movement do you do? (type/duration/frequency)

On average, how many hours of sleep do you get a night?

Typical bedtime: Typical time you wake?

Do you wake feeling rested?

On a scale from 1-10, how stressful is your life:

Work: Health status: Family/social status:

Other:

Are you satisfied with your energy levels?

What are your predominant emotions these days?

**Please list any major events in the last 10 years (or further back if it seems significant) that affected your health (mental or physical). Ex: births, deaths, break-ups, moves, accidents, job changes, illnesses**

**Anything else you'd like me to know related to your health and well-being?**

**Anything you'd like me to know that would support our work together, or that you want me to know so I can best support you?**



## Getting and Using Your Herbs

Using herbal medicine can result in profound and lasting changes in your body, your mood, your psyche, your self-awareness. After you meet with your herbalist, you'll receive an assessment and recommendations for herbs and practices to support your goals. Like most things, herbs work best the more regularly you take them. So take your herbs! Every day! Consider incorporating them into your daily rhythms and let them support you in being active in your health and self-care. For some people, the effects of herbs can take time, and are noticed subtly, and for some people the effects of herbs can be felt right away. Listen to your body. Lifestyle, somatic and nutritional practices can also support your process – and Tessa and the herbs are here to do that as well!

Accessibility and wealth redistribution is foundational to Tessa's care philosophy. They are committed to working on a sliding scale ([read more here](#)), and to supporting the most folks in accessing herbal medicine and generative care. If payment is a challenge, please be in touch to discuss options (trades, barterers, etc!)

### Consultation Rates

Initial Consultation: \$50 - \$150

Follow-up Consultation: \$25 - \$75

Acute Consultation: \$25 - \$75

Tincture: \$6 - \$12 / ounce

Tea: \$5 / ounce

Powder: \$4 / ounce

If you want to give the herbal recommendations a try, you can get them from the apothecary at Moon Root Medicinals. The first time you get herbs, you'd usually get three weeks' worth, to make sure you like the herbs and there are sitting well with you. Please let Tessa know if you have any side effects, or notice anything while starting to take new herbal formulas. To refill your herbs, call or email at least a week before you run out (more if herbs are being shipped. Herb formulas should have a number on the label (4a, for example) – please include the formula number in your refill request. Orders are usually filled on Fridays. You'll get an email with the sliding scale amount for the herbs; Payments can be made with check (email for details) venmo (@tessa-landreau-grasmuck) or paypal (choose the friends and family option) ([moonrootmedicinals@gmail.com](mailto:moonrootmedicinals@gmail.com)).

## Taking Your Herbs

**Tea/infusion:** to make an herbal tea, take the amount indicated on your label and place in a tea pot/jar/etc. Pour boiling water over herbs (I generally recommend 16-32oz of water) and cover. Steep for 30-60 mins (unless otherwise indicated), strain if desired, and drink throughout the day.

**Tea/decoction:** herbal decoctions are made of mostly roots, barks and berries simmered on low heat to extract the medicine. To make an herbal decoction, place the suggested amount with 16-32 oz of water to a pot. Cover, bring to a boil, then let simmer for 15 minute to an hour, adding more water, as needed Strain if desired and drink, hot or cold, throughout the day. You can also put the suggested amount of herbs and water into a crock pot and cook on low for 5-12 hours. Can be refrigerated for a 2-3 days.

**Tincture:** suggested dosage will be written on your tincture bottles and recommendation forms. Some are recommended to be taken first thing in the morning, and some before meals. Take as directed, but also make sure taking the herbs works for your rhythms. For tinctures, generally 1 teaspoon = 3 droppersful.

**Powder:** herbal powders are meant to be ingested, and how you do that is up to you. Some people add powders to oatmeal, or simmer in milk or coconut milk. Some add to smoothies, nut butter, add to yogurt or make [bliss balls](#). For some folks, it will be recommended that you soak the powder in cold water overnight, and then drink it all down the morning.

If you have questions or concerns about taking your herbs, reach out. If you get side effects, or feel weird as you are taking herbs, reach out. **\*If you become pregnant while taking herbs or start or change medications, reach out to Tessa ASAP to adjust herbs for safety.\***