Holistic Health Practitioner Questionnaire

Date: _____

Name: _____ Age: _____ Birth date:_____

Address: _____

Home Phone: _____ Work Phone:_____

Height: _____ Weight: _____ 1 year ago:_____ 5 years ago:_____

Occupation: _____ ☐ Full Time ☐ Part Time

Living situation: ☐ Alone ☐ Friends ☐ Partner ☐ Spouse ☐ Parents ☐ Children ☐ Pets

What are your major health concerns and intentions for your visit today?

_____

_____

_____

_____

_____

Please list any other health care providers or consultants you are currently working with:

_____

_____

_____

_____

_____

Please list any current health conditions diagnosed by a medical doctor:

_____

_____

_____

_____

When was your last physical exam?

Please list all herbs, vitamins, and dietary supplements you are currently taking, including dosage and frequency:

List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or Prescription, including dosage and frequency:

List all medications, herbs, foods, environmental factors, to which you have a known allergy:

DIETARY INFORMATION

Describe below your typical meals. Please be as specific as possible. For example, instead of "oil" note type of oil, such as olive, corn, etc. Instead of "bread" list whether white or whole grain, etc. Instead of "vegetables" list the type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include all beverages, type and quantity (two cups of orange juice, one cup of coffee, etc.,).

Breakfast:

_____

_____

_____

_____

_____

Morning snack(s):

_____

_____

Lunch:

_____

_____

_____

_____

_____

Afternoon snack(s):

_____

_____

_____

Dinner:

_____

_____

_____

_____

_____

Daily filtered or spring water consumption (number of glasses/day): _____

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.) please list as many as applicable including time of day or month:

_____

_____

_____

_____

FAMILY HISTORY

Please describe any relevant or major health related issues: (cancer, mental illness,diabetes, heart disease, etc.)

Mother: _____

Father: _____

Sister(s): _____

Brother(s):_____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

MEDICAL HISTORY

List all major health problems including any operations:

PROBLEM **YEAR**

_____

_____

_____

_____

_____

_____

_____

_____

GENERAL HEALTH

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain in heart
- ☐ Poor circulation
- ☐ Swelling
- ☐ Stroke/murmur

Skin

- ☐ Boils
- ☐ Bruises
- ☐ Dryness
- ☐ Itching
- ☐ Varicose veins
- ☐ Skin eruptions

Muscles/Joints

- ☐ Backache
- ☐ Broken bones
- ☐ Limited mobility
- ☐ Arthritis
- ☐ Bursitis
- ☐ Weakness

Respiratory

- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Tuberculosis
- ☐ Congestion
- ☐ Itchy ears/eyes
- ☐ Asthma
- ☐ Coughing up blood

Urinary/Kidney

- ☐ Excessive urination
- ☐ Water retention
- ☐ Burning urine
- ☐ Kidney stones
- ☐ Lower back pain
- ☐ Wheezing
- ☐ Circles under eyes
- ☐ Blood in urine

Gastro-Intestinal

- ☐ Belching
- ☐ Colitis
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Liver disorders
- ☐ Gallstones
- ☐ Ulcers
- ☐ Digestive troubles

Eyes, Ears, Nose and Throat

☐ Ear aches	☐ Eye pains	☐ Failing vision
☐ Hay fever	☐ Sinus infections	☐ Sinus congestion
☐ Sore throat	☐ Tonsils	☐ Hearing loss
☐ Canker sores	☐ Nosebleeds	☐ Difficulty breathing

General

☐ Fatigue	☐ Night sweats	☐ Fever
☐ Excessive thirst	☐ Loss of appetite	☐ Always hungry
☐ Difficulty sleeping	☐ Irritability	☐ Cold hands and feet

Male Reproductive

☐ Burning/discharge	☐ Lumps/swelling of testicles
☐ Painful testicles	☐ Vasectomy

Female Reproductive

Age of first period: ___	☐ Irregular cycles	☐ Pre-menopausal
☐ Heavy bleeding	☐ Blood clots	☐ Menopause
☐ Vaginal discharge	☐ Vaginal itching	☐ Pains/cramps
☐ Painful intercourse	☐ Vaginal dryness	☐ Pelvic pain
☐ Breast pain	☐ Breast lumps	☐ Anemia
☐ Infertility	☐ Genital herpes	☐ Hot flashes
☐ Mood Swings	☐ PMS	☐ Not able to conceive

Contraceptive/Pregnancy History

☐ Oral contraceptives	☐ Rhythm-method	☐ I.U.D.
☐ Diaphragm	☐ Condoms	☐ Mucous-method
☐ Cervical Cap	☐ Spermicides	☐ Fertility lens

Please list each pregnancy you have had, including miscarriages:

CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING

Please click all those that describe you:

- ☐ I am often not able to express my emotions.
- ☐ I am dissatisfied with my job.
- ☐ I am often stressed out and not able to cope properly.
- ☐ Even though I'm in a relationship, I often feel lonely.
- ☐ I often feel anxious and nervous for no good reason.
- ☐ I don't sleep well at night and have a hard time waking up in the morning.
- ☐ I often suffer from bad dreams and nightmares.
- ☐ There are many things I'd like to change in my life I just don't have the means.
- ☐ I have very low energy and often feel exhausted mentally and physically.
- ☐ I don't enjoy my work and would rather be doing something else.
- ☐ I find my children irritating and hard to relate to.
- ☐ I have very few hobbies.
- ☐ I often feel depressed for no reason.
- ☐ I often become angry with people and feel guilty about it later.
- ☐ I have a hard time letting go of the past.
- ☐ I don't look towards the future with much enthusiasm.
- ☐ I am not able to concentrate for extended periods of time.
- ☐ My outlook is more negative than positive.
- ☐ I spend a great deal of time worrying about what people think about me.

- ☐ I tend to see the good in people.
- ☐ I have a great sense of humor and love a good joke.
- ☐ I receive great joy from my family.
- ☐ My outlook on life is positive.
- ☐ My job uses all my greatest talent.
- ☐ I have plenty of energy to do all the things I want.
- ☐ I sleep well at night and feel rested in the morning.
- ☐ I can concentrate on the task at hand for as long as it takes.
- ☐ I have a strong spiritual faith.
- ☐ I am able to express anger constructively.
- ☐ I practice meditation or other relaxation techniques.
- ☐ I try to maintain peace of mind and tranquility.
- ☐ I have many close friends that I can always count on.
- ☐ I accept full responsibility for my actions.
- ☐ I trust my intuition and believe that things happen for a reason.
- ☐ I do not harbor any resentment from the past.
- ☐ I can feel completely fulfilled even if I'm alone.
- ☐ I have many hobbies and interests to keep me preoccupied.
- ☐ How I see myself is more important than how others see me.
- ☐ I often go out of my way to help others.

Please list approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, surgery, end of a relationship, loss of job, change of residence, injury, death of a loved one, etc.)

YEAR **EVENT**

_____

_____

_____

_____

_____

LIFESTYLE HABITS

Do you engage in regular physical activity? ☐ Yes ☐ No

If yes, for how many minutes? _____How often? _____

Do you smoke tobacco? ☐ Yes ☐ No

If yes, how much? _____/day

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Do you drink coffee and/or caffeinated beverages? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

How many hours of television do you watch in a week? _____

Do you use artificial sweeteners? ☐ Yes ☐ No

Please use this space to add any other information about yourself that you think will be helpful:

_____

_____

_____

_____

_____

Comments and Suggestions

Dietary Suggestions:

Recommended Herbs and Nutrients including dosage:

Lifestyle modification changes:

Relaxation techniques and exercise:

Other suggestions: