

Holistic Health History Form

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Name _____ Birth date _____ Date _____

Please answer all of the following questions as completely as possible. Your answers will be confidential as part of your medical record.

What is the main reason for your consultation?

What other issues or concerns do you have or would like advice about?

What types of treatment have you already sought or done?

Are you Underweight, Normal weight, Overweight - 10 lb, 20 lb, 30 lb, 50 lb, 100 lb? (Circle)

Are you allergic to any medications? If so, how severe (rash, can't swallow, can't breathe)? (Circle)

Are you allergic to any foods? If so, how severe (rash, can't swallow, can't breathe)? (Circle)

Are you allergic to any herbs? If so, how severe (rash, can't swallow, can't breathe)? (Circle)

List all medications you currently use: (how much, how often)

List all herbs you currently use:

List all supplements you currently use:

What illnesses do you have?

What is the condition of your teeth?

What surgeries have you had and when?

Do you have any physical limitations at this time?

Do you have any acute medical issue affecting you at this time?

What is your thinking like? _____

What are your emotions like? _____

What is your body condition? _____

How many “moons” do you count in your fingernails? (0-10) _____

What countries of origin are your grandparents from? _____

Do you smoke? If so, how much? _____

Do you drink alcohol? If so, how much? _____

Have you had any liver problems? _____

Have you had any kidney problems? _____

Have you had any lung/breathing problems? _____

Have you had any cardiac problems? _____

Have you had any skin problems? _____

Have you had any bowel problems? _____

How many bowel movements do you have in a day or week? _____

Have you ever had colonic therapy? When? _____

Do you experience any of the following: loose stools, belching, flatulence, rashes, headaches, back pain, fatigue, anxiety, depression, difficulty thinking, constipation, muscle aches, hypertension, difficulty sleeping, hyperactivity, uncontrollable behavior? (Circle each one).

Do you eat cow dairy products? If so, what kind and how much?

Do you eat grains or bread? _____

Do you eat meat? _____

Do you add sugar to any food? _____

Do you eat chocolate? How often? _____

Do you drink soda pop? How much? _____

Do you use caffeine? Coffee, decaffeinated coffee, caffeinated teas, soda pop, chocolate? Circle the ones you use and state how much?

Do you take medication for GERD or ulcers or gastritis?

Have you had any harmful environmental exposure to toxins that you know of?

Have you ever been diagnosed with or treated for ADD, ADHD, Bipolar, Depression, Autism, Schizophrenia, Chronic fatigue, Fibromyalgia, Lyme's or Restless leg syndrome? (Please circle).

Have you ever been diagnosed with HIV or hepatitis? _____

Have you ever had food allergy testing? Results? _____

Have you ever had heavy metal testing? When? _____

List your family physical health medical history.

List your family mental health history.

List your family emotional health history.

How many times at night do you get up to use the bathroom? _____

What time do you go to bed? _____

What time do you wake up? _____

Do you wake up feeling rested? _____

Do you take medication to help you sleep? _____

What recreational drugs do you or have you used?

Have you ever used narcotics for something other than a severe acute injury?

List any food cravings or addictions? _____

Have you ever used mood-controlling medications? _____

How much exercise do you get in a week? What kind?

Have you ever had depression or anxiety problems? _____

Do you experience any predominant emotional feelings? _____

When was the last time you had your thyroid lab values checked? _____

When is the last time you had any laboratory tests performed? _____

What blood type are you? _____

For women, are you still having menstrual cycles or do you use any hormone replacement?

Do you know if you are a vata, pitta or kapha person? (Circle if you know).

How much pleasure do you experience in your daily life?

How much stress do you experience in your life?

What is your financial survival stress level? _____

Do you have a spiritual or religious belief? _____

Who is your primary care doctor? (Phone #) _____

What specialists have you seen for your health care?

When was your last Chest X-ray? Normal? _____

When was your last ECG? Normal? _____

When was your last Bone density test? Normal? _____

When was your last Colonoscopy? Normal? _____

When was your last Dental work? Normal? _____

When was your last PAP smear (women)? Normal? _____

When was your last mammogram (women)? Normal? _____

Please list anything else that you want the doctor to know regarding your health and history:
