

# 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?

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

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

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When was your last physical exam?

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

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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:

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

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## 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:

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Morning snack(s):

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Lunch:

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Afternoon snack(s):

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Dinner:

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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:

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### 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**

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### 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**

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|---------------------------------------|---|---|
| <input type="checkbox"/> Ear aches    | <input type="checkbox"/> Eye pains        | <input type="checkbox"/> Failing vision       |
| <input type="checkbox"/> Hay fever    | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Sinus congestion     |
| <input type="checkbox"/> Sore throat  | <input type="checkbox"/> Tonsils          | <input type="checkbox"/> Hearing loss         |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Nosebleeds       | <input type="checkbox"/> Difficulty breathing |

### **General**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Excessive thirst    | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Always hungry       |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Irritability     | <input type="checkbox"/> Cold hands and feet |

### **Male Reproductive**

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|--|--|
| <input type="checkbox"/> Burning/discharge | <input type="checkbox"/> Lumps/swelling of testicles |
| <input type="checkbox"/> Painful testicles | <input type="checkbox"/> Vasectomy                   |

### **Female Reproductive**

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|--|---|---|
| Age of first period: ____                    | <input type="checkbox"/> Irregular cycles | <input type="checkbox"/> Pre-menopausal       |
| <input type="checkbox"/> Heavy bleeding      | <input type="checkbox"/> Blood clots      | <input type="checkbox"/> Menopause            |
| <input type="checkbox"/> Vaginal discharge   | <input type="checkbox"/> Vaginal itching  | <input type="checkbox"/> Pains/cramps         |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Vaginal dryness  | <input type="checkbox"/> Pelvic pain          |
| <input type="checkbox"/> Breast pain         | <input type="checkbox"/> Breast lumps     | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Infertility         | <input type="checkbox"/> Genital herpes   | <input type="checkbox"/> Hot flashes          |
| <input type="checkbox"/> Mood Swings         | <input type="checkbox"/> PMS              | <input type="checkbox"/> Not able to conceive |

### **Contraceptive/Pregnancy History**

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|--|--|---|
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Rhythm-method | <input type="checkbox"/> I.U.D.         |
| <input type="checkbox"/> Diaphragm           | <input type="checkbox"/> Condoms       | <input type="checkbox"/> Mucous-method  |
| <input type="checkbox"/> Cervical Cap        | <input type="checkbox"/> Spermicides   | <input type="checkbox"/> 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

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### 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:

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