



Tree Of Life Holistic Wellness Center

CLIENT INFORMATION AND HEALTH ASSESSMENT FORM

Complete the following form with as much information as you can provide. The form is lengthy, but you will only fill it out once. This information will be carefully analyzed in order to provide you with the best possible service and follow-up support.

CLIENT INFORMATION

1. Name: _____
2. Address: _____
3. Home Phone: _____
4. Work Phone: _____
5. Email Address: _____
6. Birth Date: _____
7. Height: _____
8. Weight: _____
9. Gender: M ___ F ___
10. Blood Type(if known): A ___ B ___ AB ___ O ___
11. Primary Care Physician's Name: _____
12. Physician's Phone Number: _____
13. Are you under the care of any other health care professionals? Y ___ N ___
14. If so, Conventional _____ or Alternative _____
15. If you answered yes to #14, please list names and reasons for using them. _____

16. List your four most important Health Issues and/or Wellness Goals.
 - A. _____
 - B. _____
 - C. _____
 - D. _____

17. List any physician diagnosed illness you are presently experiencing: _____

DESCRIPTION of PRIMARY COMPLAINT

18. Please indicate any diagnosis that has been made regarding this complaint. _____

HISTORY of YOUR PRIMARY COMPLAINT

19. When did you first realize that this health related situation existed?

20. Describe the main symptoms you are experiencing. _____

21. If there is pain involved, on a scale of 1-10 how would you describe the intensity (10 being the most painful)? _____

22. Please describe the timing-duration/location and radiation (if any) of the pain. _____

23. What, if any, are the factors that relieve the pain or make it worse?

24. Are there any other specific symptoms you would like to mention about this issue _____

25. Did you experience any major childhood illnesses?

26. If yes, acute _____ chronic _____

27. If yes, Please explain _____

28. As a child did you experience any significant physical traumas?

29. If yes, please describe. _____

30. Were there any past prescriptions taken (ones you are no longer taking)? _____

31. If yes, Please lists them. _____

32. Were any past surgeries performed? _____

33. If so, please list them. _____

34. Any past personal history of psychological traumas or diagnoses made? _____

35. If yes, please describe. _____

PRESCRIPTION MEDICATIONS (currently being used-list each one separately)

36. Are there currently any prescription medications being taken? _____

37. If so, please list their names individually, along with what they are being used for; How often they are taken per day/per week/episodically; size of each dose (mg); and how long you have been taking each medication. _____

OCCUPATIONAL-ENVIRONMENTAL FACTORS

38. Are there any job related physical stresses or exposure to excessive noise, solvents-chemicals, or poor air quality that you feel might be contributing to your health issues? _____

FAMILY HISTORY

39. Are your parents still living? _____

40. If no, cause of death and age of death. _____

41. If yes, please describe any health conditions that your parents were diagnosed with. _____

42. Are your grandparents still living? _____

43. If no, cause of death (if known) and age of death. _____

44. If yes, please describe any health conditions your grandparents were diagnosed with. _____

45. Do you have any siblings with chronic disease issues? _____

46. If yes, please describe. _____

47. Are there any chronic disease patterns that run in either side of your family? _____

48. If yes, please describe. _____

OVER THE COUNTER DRUGS/MEDICATIONS

49. Are you currently taking over the counter medications? _____

50. If so, please list individually along with how often and dosage; why you use this medication and how long it has been used. _____

VITAMINS/MINERALS/HERBS/other SUPPLEMENTS

51. Please list any nutritional supplements or herbs taken, along with how much you are taking of each of _____

them. _____

KNOWN ALLERGIES/SENSITIVITIES

52. Do you suffer from any allergies airborne, food, or chemical? _____

53. If yes, please list and note if the allergy is mild, moderate, severe or life threatening. _____

Are these allergies seasonal or constant? _____

LIFESTYLE SECTION

Dietary Habits

54. List as many as possible, items that you typically eat each week for the following mealtimes. Include items eaten at home and/or take-out/restaurant foods. If you do not eat three meals per day, then note which meal(s) you normally skip after that section.

Breakfast _____

55. Lunch _____

56. Dinner _____

57. Snacks: (list snack items you normally consume; e.g. candy, chips, ice cream, crackers, etc. If you eat primarily healthy type snack foods please list them as well; e.g. fruit, yogurt, veggie sticks, etc. _____

58. Liquids intake:

a. What is the main type of beverage you drink (coffee, tea, soda etc.)? _____

b. Type of water you drink most often (spring, faucet, etc.)? _____

c. How many 8oz. Glasses per day? _____

d. Do you drink soda? _____

If yes, what type primarily? Regular/caffeine ____ Regular/non-caffeine
____ Diet/caffeine _____

e. Do you drink coffee? ____ if yes, regular _____ de-caf. ____ How many cups per day? _____

f. Do you drink milk? ____ how many glasses per day? _____

g. Do you drink alcoholic beverages? _____

If yes, please list type and how much per week. _____

OTHER LIFESTYLE CONSIDERATIONS:

- 59. Do you use tobacco products? _____
- 60. If yes, what type and how much? _____
- 61. Please list the amount of times per week that you exercise, type of exercise and duration of exercise session. _____
- 62. Do you use any relaxation or stress management techniques? _____
- 63. If yes, what types? _____
- 64. Do you have difficulty sleeping? _____
- 65. If yes, please describe; e.g. trouble falling asleep/wake-up in middle of night/"racing mind"/restless legs" nightmares/breathing difficulties. _____

- 66. On average, number of hours of sleep per night? _____

BODY SYSTEMS ASSESSMENT SECTION

Please place a check mark next to any items that apply to you or a N/A if it does not apply to you. For each item that you placed a check mark by, placing a number in the box to the right of each item that applies to you. Use a (1) if the item is a constant issue for you; use a (2) if it comes and goes on a regular basis(daily, weekly, monthly); use a (3) if it only occurs a couple of times per year.

Group One

- 67. Mouth ulcers _____
- 68. Gum Disease _____
- 69. Dry Mouth _____
- 70. Excess Salivation _____
- 71. Foul smelling burps/belching _____
- 72. Nausea in morning _____
- 73. Nausea in evening _____
- 74. Loss of taste sensation _____
- 75. Burning gut sensation, eating relieves _____
- 76. Eating causes burning sensation in gut _____
- 77. Eating calms you down _____

78. Indigestion (general)_____
79. Indigestion immediately after eating_____
80. Indigestion form ½ to 3 hours after eating_____
81. Stomach feels bloated after meals_____
82. Heart burn (burping up acid)_____
83. Tongue coated (white fur)_____
84. Tongue coated (yellow fur)_____
85. Indentations from teeth visible on sides of tongue_____
86. Poor appetite_____
87. Strong appetite_____
88. Defecate shortly after eating_____
89. Lower bowel gas several hours after eating_____
90. Pass large amounts of foul smelling gas_____
91. Diarrhea w/gas_____
92. Constipation w/gas_____
93. Constipation w/ painful defecation_____
94. Alternating constipation and diarrhea_____
95. Mucus in stools_____
96. Dark colored(black), soft stools_____
97. Hemorrhoids_____

GROUP TWO

98. Headaches_____
99. Migraines_____
100. Dizziness_____
101. Dry skin, scaly_____
102. Dry scalp or hair_____
103. Oily scalp_____
104. Excessive loss of hair_____
105. Itch skin and feet_____
106. Burning feet_____
107. Skin cracks/peels on soles of feet_____
108. Psoriasis_____
109. Eczema_____
110. Frequent skin rashes_____
111. Hives from foods or drugs_____
112. Acne on face AND buttocks_____
113. Pimples, on surface, come to a head_____
114. Pimples/boils, deep/sores, not coming to head_____
115. Hay fever/allergies_____
116. Milk product cause upset stomach_____
117. Sneezing attacks_____

118. Nightmares/bad dreams _____
119. Bitter/metallic taste in mouth in morning _____
120. Bad breath _____
121. Headaches upon awakening then get better _____
122. Feel queasy, headache over eyes _____
123. History of gallbladder/stones _____
124. Greasy-fatty foods upset stomach _____
125. Craves proteins/fats _____
126. Craves sweets or fruit _____
127. Bowel movements painful/difficult _____
128. Use of laxative frequent _____
129. Stools light colored (light yellow to clay color) _____
130. Stools hard, marbled _____
131. Burning in anus _____
132. Itching anus _____
133. Pain between shoulder blades _____
134. Tendency to worry _____
135. Easily angered _____
136. Feeling of insecurity _____

GROUP THREE

137. Hands and feet go to sleep _____
138. Hands and feet get cold easily _____
139. Hands warm, sweaty _____
140. Hands cold, clammy or dry _____
141. Hands/feet turn white or purple when cold _____
142. Warm bodied _____
143. Cold bodied _____
144. Noise or ringing in ears _____
145. Dizzy or faint sometimes _____
146. Nose bleeds _____
147. Heart palpitates or beats erratically occasionally _____
148. Heart beats very fast sometimes _____
149. Shortness of breath on exertion _____
150. High blood pressure (using meds.) _____
151. High blood pressure (moderate, no meds.) _____
152. Low blood pressure _____
153. Tendency toward anemia _____
154. Swollen ankles, worse at night _____
155. Bruise easily, have black and blue spots _____
156. Muscle cramps after exercising _____
157. Legs cramp "Charley Horse" _____

- 158. Pain in legs after walking a short distance _____
- 159. Spider veins on legs _____
- 160. Varicose veins _____

GROUP FOUR

- 161. Dry nose _____
- 162. Nose itches often _____
- 163. Runny nose w/clear discharge _____
- 164. Stuffy nose (constant) _____
- 165. Stuffy nose (in morning) _____
- 166. Stuffy nose (after eating certain foods) _____
- 167. Hay fever (seasonal allergies) _____
- 168. Earaches _____
- 169. Sore throats often _____
- 170. Hoarseness often _____
- 171. Sinus infections (dry, little discharge) _____
- 172. Sinus infections (dry, discharge clear) _____
- 173. Sinus infections (wet, discharged, yellow-green) _____
- 174. Mucus in back of throat in morning _____
- 175. Frequent chest colds _____
- 176. Bronchitis _____
- 177. Asthma (dry, little mucus) _____
- 178. Asthma (wet, much mucus) _____
- 179. Rapid, shallow breathing _____
- 180. Shortness of breath when standing or walking _____
- 181. Sigh frequently (take deep breath to get air) _____
- 182. Afternoon "Yawner" _____
- 183. Get drowsy often _____
- 184. Desire to open windows in a closed room _____
- 185. Aware of breathing heavily _____
- 186. Snore _____
- 187. Snore with occasional gasping breath _____
- 188. Snore with occasional momentary breath cessation _____
- 189. Sometimes wake up gasping/choking for breath _____
- 190. Sometimes hyperventilate _____

GROUP FIVE

- 191. Sweating when feverish _____
- 192. Lack of sweat when feverish _____
- 193. Low-grade fevers _____
- 194. Slow to heal or recuperate from illness _____

- 195. Tender, swollen glands under jaw or on neck _____
- 196. Frequent sore throats or colds _____
- 197. Cold sores (on lip/in nose) _____
- 198. Rheumatoid arthritis _____

GROUP SIX

- 199 Dry eyes _____
- 200. Insomnia _____
- 201. “Restless legs” at night _____
- 202. Strong appetite, can’t gain weight _____
- 203. Can’t tolerate heat _____
- 204. Skin flushes easily _____
- 205. Night sweats _____
- 206. Feeling of “trembling” inside _____
- 207. Panic attacks _____
- 208. Heart palpitates _____
- 209. Eyelid/facial twitching _____
- 210. Restless/irritable often _____
- 211. Tend to gain weight _____
- 212. Lack of appetite _____
- 213. Fatigue easily/feel tired all day _____
- 214. Ringing in ears _____
- 215. Can’t tolerate cold _____
- 216. “Fuzzy” thinking _____
- 217. Dry, scaly skin _____
- 218. Hair is coarse, dry, falls out _____
- 219. Slow pulse, below 65 _____
- 220. Urinate frequently _____
- 221. Hearing problems _____
- 222. Lack enthusiasm _____
- 223. Low blood pressure _____
- 224. Increased sexual drive _____
- 225. Lack of sexual drive _____
- 226. Tendency toward ulcers/colitis _____
- 227. Abnormal thirst _____
- 228. Hungry between meals _____
- 229. Irritable between meals _____
- 230. Feel “shaky or lightheaded” if you don’t eat _____
- 231. Heart palpitates if meals missed _____
- 232. Afternoon headaches _____
- 233. Afternoon fatigue _____
- 234. Crave coffee/sweets in afternoon _____

- 235. Get “the blues”/depressed often sleep _____
- 236. Pulse speeds up after meals _____
- 237. Unable to relax, startle easily _____
- 238. Strong light irritates _____

GROUP SEVEN

- 239. Lower back pain _____
- 240. History of kidney stones _____
- 241. Bladder infections or history of same _____
- 242. Incontinence (stress related) _____
- 243. Incontinence (age related) _____
- 244. Urination (sudden need to) _____
- 245. Urination (frequent, small amounts) _____
- 246. Urination (infrequent, large amounts) _____
- 247. Urine cloudy _____
- 248. Urine always light colored/clear _____
- 249. Urine has strong odor _____
- 250. Frequent thirst _____
- 251. Wake up more than once at night to urinate _____
- 252. Standing quickly causes pulse to “roar” in ears _____
- 253. Feel faint/dizzy when standing too quickly _____
- 254. High blood pressure _____
- 255. Moderately high blood pressure _____
- 256. Low blood pressure _____
- 257. Crave fats _____
- 258. Crave sweets _____
- 259. Crave salt _____

GROUP EIGHT

- 260. History of osteoarthritis _____
- 261. History of rheumatoid arthritis _____
- 262. History of gout _____
- 263. Muscle pain _____
- 264. Muscles cramp easily after exertion _____
- 265. Pains that move around _____
- 266. Stiffness in the mornings _____
- 267. Joints painful/hot _____

GROUP NINE (FOR WOMEN ONLY)

- 268. Menopause: (check one) _____

269. Pre-menopausal _____
270. Peri-menopausal _____
271. Post Menopausal _____
272. Hysterectomy/ovaries removed _____
273. Hysterectomy/ovaries not removed _____
274. Do you use birth control pills? _____
275. Menstrual cycle exceeds 28 days _____
276. Menstrual cycle less than 28 days _____
277. Menstrual cycle erratic _____
278. Premenstrual tension _____
279. Water retention before menses _____
280. In hips and breasts _____
281. In hands and feet _____
282. Menstrual cramps(Painful/excessive) _____
283. Palpitations before menses _____
284. Breast tenderness before menses _____
285. Mood swings before menstruation _____
286. Crave sweets before period _____
287. Craves fats/proteins before menses _____
288. Menses excessive _____
289. Menses prolonged _____
290. Menses scanty _____
291. Sometimes bleed between periods _____
292. Frequent candida type infection _____
293. Frequent bladder infections _____
294. Abnormal pap smears _____
295. Miscarriages, problem pregnancies _____
296. Difficulty conceiving _____
297. Menopausal related symptoms: _____
298. Hot flashes _____
299. Night sweats _____
300. Vaginal dryness/painful intercourse _____
301. Insomnia _____
302. Fatigue _____
303. Depression _____
304. Bleeding _____
305. Hypertension _____
306. Osteoporosis _____
307. Stress incontinence _____