Holistic Family
POINTING YOUR FAMILY TO WELLNESS

Client Information

Name _____Age_____Date_____

Phone _____Mobile_____Email_____

Address_____

Date of birth_____Current Weight_____Height_____

Email _____

Occupation_____

Who referred you?_____

When and Where did you last receive medical care?_____

_____

For what reason?_____

Why are you here today? _Please list your top three concerns :

_____

On a scale of 1-10, 10 being the highest level, what is your commitment level to restoring or maintaining your health? Circle the number that is most accurate of your level of interest and commitment at this time: **1-2-3-4-5-6-7-8-9-10**

Please list any and all medications you are taking, including painkillers, laxatives, and vitamins and other supplements?_____

_____

_____

_____

Please list your general diet for most of your life: (be truthful!)

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

How Often?_____

Please answer the following questions as accurately as possible, based on a typical day. The only way I can fully help you is to have the most current and accurate information.

Do you eat:	Often	Sometimes	Never
Eggs	____	_____	_____
Fruits	____	_____	_____
Meat	____	_____	_____
Salads	____	_____	_____
Chicken	____	_____	_____
Cooked Veg.	____	_____	_____
Fish	____	_____	_____
Coffee	____	_____	_____
Milk	____	_____	_____
Potatoes	____	_____	_____
Cheese	____	_____	_____
Rice	____	_____	_____
Butter	____	_____	_____
Pasta	____	_____	_____
Yogurt	____	_____	_____
Breads	____	_____	_____
Sugar	____	_____	_____
Salt	____	_____	_____
Fermented Foods	____	_____	_____

Would you say you eat a lot of junk food? Y __N__ If you drink coffee, how many cups per day?_____ Do you smoke? Y__ N ___ Do you crave sweets? Y___ N___

Chocolate? Y ___N___ Do you drink alcohol? Y__ N___. If yes, how many drinks per week? _____

How do you sleep?_____

From a scale of 1-10, 10 being the highest, rate your energy level: Circle the number that is most accurate: **1-2-3-4-5-6-7-8-9-10**

Do you have bowel distress such as gas, pain or constipation?
_____Never_____Sometimes_____ Always

Do you eat sushi? (raw fish) Y N If yes, how often?_____

Do you have pets? Y___ N___ Type: _____

Do you exercise? Y___ N___ Type_____

How many times a week_____ How many glasses of water do you drink a day? _____

Have you had any major emotional traumas that you feel have affected your health? Y N
When_____
_____

Are you spiritual, religious or do you have a belief in a higher power?_____

Do you have any internal or external contagious
illness?_____
_____

How many times a year do you fly in a plane?_____

How often are you on your phone or computer?_____

Do you eat only organic food?_____

What types of cleaning and body products do you use?_____

Do you suffer from allergies? Seasonal or other?_____

Have you ever completed an internal cleansing program? If yes, when and what
type?_____
_____

From a scale of 1-10, 10 being the highest, rate your stress level: Circle the number that is most accurate

1-2-3-4-5-6-7-8-9-10

What would you say is the biggest contributing factor to your stress?_____

_____

To your knowledge, have you ever lived or worked in a damp or moldy building?_____

_____

Do you suffer from any illness of any system, i.e. heart disease, kidney disease, diabetes, chronic or acute respiratory illness?_____

_____

Do you experience hypermobility or stiffness?
Describe_____
_____

Do you experience frequent static/electric shocks?

_____
_____

Do you urinate frequently?_____

Do you feel thirsty frequently?_____

Do you or have you ever had any allergic reaction to any substance, food or non-food item?_____
_____
_____

Have you ever been tested for food sensitivities?_____

Have you ever suffered from skin disorders such as acne, eczema, psoriasis, hives, or rashes?_____

_____

Have you ever had a major surgery, been hospitalized, or treated for anything other than a minor illness (cold, flu)? When and what for?_____
_____
_____
_____
_____
_____

Were you born via caesarean or vaginal birth?_____

Do you know your mother's state of health during her pregnancy with you?_____

_____

FEMALE ONLY:

Are you pregnant, nursing, or trying to become pregnant?_____

How many children do you have?_____

Have you ever had really painful, heavy or irregular periods, fibroids, cysts in breasts or on ovaries or any hormone related disorder?_____