Holistic Healthcare New Client Evaluation

Name
Date of birth
Address
City State Zip code
Cell phone Home phone
Work phone E-mail
Current occupation
Emergency contact Phone number
Weight Height

Who referred you?
What is it you hope to achieve with this visit?

Name of Primary Care Dr. Other health care practitioners?
Date of last physical?
Any known imbalances?
Blood type:

Past surgeries?

Allergies? (Including Latex Antibiotics Sulpha Penicillin)

Present health
Please describe your present health problems and their duration.
1.

2.

3.

How long have you had the chronic conditions about which you are consulting me?
Less than 6 months__ 6 months to 2 years__ 2–5 years__ more than 5 years__
How have your health problems progressed since they began?
Stable__ Gradually improving__ Rapidly improving__ Fluctuating__
Gradually worsening__ Rapidly worsening__
Please indicate the overall intensity of your symptoms.
Mild__ Moderate__ Severe__ Very severe__
How often are you having pain or discomfort?
Less than once per week__ Several times per week__ Once a day__
Several times per day__ Most of the time__
Do you take any nonprescription drugs or vitamins or any other supplement/s, such as herbal or homeopathic remedies? Please list them.

Are you currently under the care of a family physician or any other health professional?

If yes, include details.

Do you currently take medication and/or receive medical treatment for your health condition(s)?
If so, include all medications, treatments, and dosages.

Do you have any past medical history or problems (i.e., illness, surgeries, trauma, emotional stress, addictions, or anything else that will help us clearly understand your health condition)?

Is there a family history of the health problem(s) listed above? Yes No If yes, please specify

Childhood illnesses?
Health as a child: Good Fair Poor

Scarlet fever	Mumps	Chicken pox	Pertussis	Bronchitis	Pneumonia
German measles	Measles	Diphtheria	Rheumatic fever	Polio	Acne

Family history- Any pertinent family health history?
Indicate Self, M-mother, F-father, S-sister, B-brother, GM-grandmother, GF-grandfather, C-children

Anemia	Diabetes	Cancer	Epilesy
Glaucoma	Heart disease	High blood pressure	Hay fever
Hives	Kidney disease or stones	Rheumatoid arthritis	Mental illness
Tuberculosis	Stroke	Syphilis	Other

Digestion

Indigestion	Foods that irritate	Any “itis”
Belching/farting	Irritable bowel	Gall stones
Bloating	Constipation	Liver problems
Eye pains/dry/wet	Diarrhea	Abdominal pain
Floaters light/dark	Alternating	Nausea
Trouble swallowing	Pain? Where?	Foreign travels?

Describe your bowel movements.
Once every 2–3 days__Once daily__2–3 times per day__ First thing in the morning__
Late in daytime__ Immediately after meals__ Immediately after dinner__
Need laxative daily__ Other (please specify)
Bowel nature:
Soft__Medium__Hard__
Bowel movement associated with:
Pain Blood Mucous Foul smell

Respiratory

Allergies? Since when?	Hay fever	Asthma sport related

Sinus infection	Sore ribs	Bronchitis as a child
Sinus congestion	Ear aches	Wet lungs
Difficulty breathing	Sore throat	Tuberculosis
Post nasal drip	Base of throat cough	Dry cough

Flu or cold recur every winter?

Use of antibiotics and if so, how often?

Do you delay or suppress any of the following?
Sleep Bowel movements Gas Urination Yawning
Burping Thirst Breathing Semen Hunger
Sneezing Tears

Do you travel often? Yes No

Do you do self-massage with oil daily? Yes No

Exercise
How often do you exercise?
Daily Weekly, four times Weekly, three times Weekly, twice
Weekly, once Not at all

What type of exercise do you do?

How long do you exercise each time?

Rate the intensity of your exercise. Light Moderate Vigorous

Dietary habits

Do you eat between meals? Yes No
Do you eat your meals at regular times? Yes No
Which is your biggest meal? Breakfast Lunch Dinner
Rate your digestion. Good Fair Bad
How much water do you drink per day(1 glass=8 oz.)? None 1–2 Glasses 3–4 Glasses
5–6 Glasses 7+ glasses Filtered?
Eat with my full attention on food__ Converse a lot while eating__ Eat very quickly__
Watch television while eating__ Rarely sit down to eat__
Eat meals regularly? Skip meals? Eat snacks between meals?

Unusual cravings?

Chew well? Weight loss/gain Enjoy your meals?

Organic, locally grown Compulsive eating? Emotional eating?

Cook own meals? Microwave? Eat out, if so how often?

Drink with meals?
Soda? If so, what kind? Tea? If so, what kind? Juices? If so, what kind?

Describe a typical breakfast

Salt your food? Sea salt, Kosher Snacks
Oils used to cook with, olive, etc Fried foods
Packaged or frozen food?
Eat or drink before bed? After eating how do you feel?
Cravings?
What foods do you favor:
Salty Sweet Sour Bitter Starches Fats
Astringent Dairy products

How many times a day/month/week do you eat the following?
Protein Sugar Carbohydrate Fermented foods

Red meat	Maple syrup	Vegetables green	Miso
Poultry, free range	Raw sugar	Vegetables yellow	Sauerkraut
Fish	Brown sugar	Vegetables orange	Ketchup
Kidney, black, pinto, adzuki	Honey	Vegetables red	Pickles
Wild meats	Refined sugar	Vegetables white	Umeboshi
Soy foods	Chocolate	Rice, white	Yogurt
Eggs	Baked goods	Rice brown, wild	Kefir
Dairy: organic?	Ice cream	Oats	Vinegar
Milk cheese yogurt	Candy	Millet, barley, bulgur	
Quality of meats	Packaged cereal	Pasta	
Green drinks	Equal/NutraSweet	Bread	
Mushrooms, a variety?	Fruit	White flour	
Nuts		Seeds	
Seaweeds?		Chips, fries, crackers, pretzels	

Skin, Muscles, and Joints
Itching
Eczema/psoriasis
Rash
Broken bones
Dryness Position sleeping
Eruptions, where on the body? What is their appearance?

Hives
Boils
Warts

Inflammation

Anything unusual or causing difficulties?

Do you practice any type of meditation? Please explain.

Do you practice yoga or any form of exercise? Please explain.

Which type of weather makes you feel most uncomfortable?
Cold Hot Cool and damp
Which weather/season is most comfortable to you?
Are you allergic to any substances?
Food__ Pollen__ Dust__
Other (please specify)
Do you smoke cigarettes (or other substances)? Yes No
If yes, how many per day? 1/2 pack 1 pack 2 packs More than 2 packs
How often do you drink alcohol?
Never__ Less than once a week __ About once a week__
Several times a week__ Once a day__ More than once a day__
How much at a time?
How often do you drink caffeinated beverages?
Never 1 cup daily 2–3 cups daily 4–5 cups daily
How would you rate your usual energy level?
Very high High Moderate Low Very low
Do you experience any of the following?
Depression__Anxiety__Fear or Panic__Loneliness__Worry__
High stress level__ Anger__Lack of memory__Light-headedness__
Lack of energy__Suicidal thoughts or attempts__Irritation__

Social history
How are your family relationships? Excellent__Good__Fair__Poor
How is your social life? Excellent__ Good__Fair__ Poor__
How is your mental health? Excellent__Good__Fair__ Poor__
How is your career? Love it__ Like it__It's bearable__ It's unbearable__
How purposeful does your life feel?
Completely Somewhat Neutral Purposeless
Rate your spiritual life.
Fully satisfying__Somewhat satisfying__Neutral__Empty__
Please indicate which of the following areas are troublesome (if any).
Hernias__ Sexual difficulty__ Urination__ Erection problem__ Libido__
Birth control__ Prostate problems__ Discharge or sores__ Venereal disease__
Testicular masses__

Age menses began:
Which of the following describes your menstruation?
Regular__ Irregular__ Too frequent__ Absent__ Ceased due to menopause__
How many days does your menstrual period last?
1–4 days 5–7 days More than 1 week Irregular throughout the month
Other

How is your menstrual flow?
Normal__ Heavy__Light__Abnormal vaginal discharge__
Do you have any associated symptoms (before or during menstruation)?
None__Pain__Fluid retention__Migraine__Depression__
Acne__Tension__Nightmares__Frustration__Loneliness__
Do you have any discharge outside of your menstrual period? Yes No
Do you ever experience pain during intercourse? Yes No
Are you pregnant now? Yes No Don't know
Do you have any sexual difficulties? Yes No
If yes, please explain.
Do you take contraceptive pills or use other forms of birth control? Yes No
If yes, please explain.
Number of previous pregnancies
Do you have any history of abortion, miscarriage, or problems related to pregnancy or labor? If yes, explain.
How many children do you have?
How old are your children?
Do you do a breast self-exam regularly? Yes No
Do you experience any of the following? Pain or tenderness Lumps Nipple discharge
Other comments (please include anything else you would like me to know)Use back of form if more space needed.

I understand that this is an educational Holistic Healthcare consultation for the purpose of helping me improve my health and wellness. I understand this does not include medical diagnoses or treatment and is not a substitute for medical care.

Client signature_____Date_____

I understand that Crystal Davidson is a Holistic Healthcare Practitioner and Educator who provides me with information with a holistic approach to health care, which may affect my diet and health in a positive way.
I understand that Crystal Davidson is not a medical doctor or licensed medical practitioner, has not presented herself as such, and does not seek to diagnose, treat, or prescribe for disease or other pathological conditions.
I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought this consulting service.
I agree that I may consult a licensed physician for any concern, at any time, about any disease or pathology that now exists or arises during my professional relationship with Crystal Davidson.
Furthermore, I understand that Crystal Davidson encourages regular medical checkups from a licensed medical professional of my choice, and that any medication that I am now taking
upon my licensed physician's advice, or will take in the future, is taken strictly according to my licensed physician's directions. Only a licensed physician of my choice can advise on medication dosages or the discontinuance or resumption of such medications.
My signature below acknowledges the above statements as fully read and understood.
Client's signature_____ Date_____
Herbal Practitioner signature_____ Date