



# *Tree Of Life Holistic Wellness Center*

**3310 Churn Creek Suite B  
Redding California  
530-722-6728**

## **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 \_\_\_\_\_