
# *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_____