The Whole Homestead

Personal Health Overview

Note: Information provided on this forms will be held in strict confidence.

I. Personal Information

Name_____

Age _____ Gender _____ Height_____ Eye Color _____

Current Weight _____ One year Ago _____ 5 Years Ago_____

Phone Number/Skype Number/FaceTime you wish to be contacted at_____ Email:_____

Preferred form of contact: _____ Best time(s) to call:_____

Occupation:

_____

Who do you share your home with: _____

Number of children: _____ Age(s): _____

What are the areas of current complaint that you would like to address with an herbal program?

_____

_____

_____

Please list all physicians and/or other healthcare providers/ consultants (such as Acupuncturist, massage therapist, etc) you see on a regular basis:

Name Location Type of Service

_____

_____

_____

_____

_____

II.Diet, Nutrition & General Health

On Average, how many servings do you have per day of …….?

Food (serving size)	Servings	Food (serving size)	Servings
Fresh Fruits (1/2 cup servings)		White Bread (1 slice)	
Fresh Vegetables (1/2 cup servings)		Refined Sugar (1 teaspoon)	
Green Leafy Vegetables (1/2 cup servings)		Cookies, cakes, pastries	
Fresh or Frozen Fish (3-4 ounces)		Alcohol (1 oz.)	
Poultry (Chicken or Turkey) (3-4 oz.)		Coffee (1 cup)	
Red Meat (3-4 oz.)		Soda Pop (8 oz.)	
Seafood (Shrimp, Crab, etc.) (3-4 oz.)		Artificial Sweeteners	
Milk (1 cup)		Soymilk or other milk substitute (1 cup)	
Butter (1 oz.)		Margarine (1 oz.)	

What are the worst foods that you tend to come back to or have a weakness for?_____

_____

_____

Are you subject to binge eating? _____ If so, what foods_____

_____

Do you experience Bloating or Gas after meals? _____
Indigestion or heartburn? _____ Do you feel Sleepy or Tired after meals? _____ How often? Daily /Weekly /Occasional
Are you on a Restricted Diet? _____
Explain:_____
When is the last time you took antibiotics?

_____

Do you feel agitated or/extreme low energy if you don't eat regularly?

_____

Daily water consumption (# glasses/quantity/day): _____
What kind of water do you drink? _____
Do you eat breakfast every day? _____

Do you eat regular meals? _____ Are you currently_____
allergic to any foods? _____
Please list any known food allergies/sensitivities (attach additional sheets if needed):

Food Describe Reaction

_____

_____

_____

_____

Do you have any other allergies?
_____

How many hours of sleep do you get each night, on average?_____
How do you sleep?_____
What is your energy level like?_____
How often do you exercise?_____ Hours per_____
How often do your bowels eliminate?_____
Do you ever have hard stools? ____ Do you ever have loose stools? ____ Urination: normal ____ scanty ____ more than 5 times daily ____burning _____ strong odor ____ dark color _____
Any history of bladder or kidney infections? _____ If so, at what age? ____ Are you currently pregnant or nursing a baby?____
Are you under stress? If so, explain._____

_____

_____

_____

What nutritional supplements are you currently taking (attach a separate sheet in necessary?)_____

_____

_____

_____

_____

III. MEDICATIONS

List all medications you are currently taking and what they are taken for (including aspirin, antacids, etc.), indicating whether they are over the counter (OTC) or prescription (P):

(Use additional additional paper if needed.)

Name of Product/used for OTC or P? Dosage Frequency (#/day)

_____

_____

_____

_____

_____

List all medications, herbs, etc., to which you have a known allergy:

_____

_____

_____

IV. COMMON PHYSICAL ACTIVITIES:

__Desk Sitting (how long) __Standing (how long?) __Sitting in a car (how Long) __Jogging/Running __Calisthenics __Aerobics __Swimming __Weight Lifting __Walking __Yoga __Tai Chi __Hiking __Bike Riding __Horseback Riding __Tennis __ BendingLifting __Other_____

Do any of the conditions above aggravate a current health condition?
Have you had any operations? ____ What year? _____
Any major injuries/accidents?____ What and when? _____
Any major illness or hospitalizations? ___ What and when? _____

V. PAST MEDICAL HISTORY:

Serious Accidents, injuries, head trauma:

Surgical History:

Hospitalizations:

VI. FAMILY HISTORY: (List any medical conditions, problems in family members)

Father: _____

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Other family members with pertinent issues, or recurring family health trends?

VII. LIFESTYLE: (Leave blank if not applicable to you!)

ALCOHOL USE: Average amount per day_____ per week_____
TOBACCO USE: Average amount per day_____ per week_____
CAFFEINE USE: Average amount per day _____ per week_____
OTHER DRUG USE: PAST Average amount per day_____per week_____

VIII. CURRENT HEALTH STATUS

Check each column where symptoms apply and elaborate in space provided below if necessary. Please indicate with a √ any experiences below that you sometimes experience; two checks √√ for those which occur often; and use three checks √√√ for those which are a major concern.

Cardiovascular
_____High Blood Pressure
_____Low Blood Pressure
_____Pain in Heart
_____Poor Circulation/cold extremities
_____Swelling in Ankles/joint
_____Previous heart stroke/murmur
_____High Cholesterol
_____Anemia

Skin
_____Boils/Acne
_____Bruises
_____Dryness
_____Itching
_____Varicose Veins
_____Skin eruptions
_____Wounds heal slowly
_____Eczema

Muscles/Joints
_____Backache/upper or lower
_____Broken Bones
_____Arthritis/Bursitis
_____Mobility Restriction
_____Fibromyalgia/MS
_____Auto-Immune

Respiratory
_____Chest Pain
_____Difficulty breathing
_____Cough
_____Congestion
_____Tuberculosis
_____Asthma

Eyes, Ears, Nose, and Throat
_____Asthma
_____Ear Aches
_____Eye Pains, Dry/Wet
_____Failing vision
_____Hay Fever
_____Sinus Infection
_____Sinus Congestion
_____Sore Throat
_____Tonsils
_____Hearing Loss/Ringing Ears

Gastro-Intestinal
_____Belching
_____Colitis
_____Constipation
_____Abdominal Pain
_____Liver Problems
_____Gall Stones
_____Ulcers
_____Indigestion

Sleeping Patterns
_____Insomnia
_____Waking in the night
_____Nite sweats
_____Restless sleep
_____Wake up tired
_____Lower Back Pain

Urinary/Kidney
_____Kidney Stones
_____Excessive Urination
_____Water Retention
_____Burning Urine
_____Difficulty falling back to sleep
_____Dark circles under eyes

Miscellaneous
____Usually feel Hot/Warm ____Usually feel Cold/Cool____Emotional Insecurity

Do you have headaches?_____How often?_____

What are they like?_____

Do you know what causes them?_____

WOMEN'S HEALTH:

Do you experience any of the following, past or present?
PLEASE CIRCLE

Breast pain Hot flashes Difficult menopause Irregular PAP
Irregular menstrual cycles Ovarian cysts Vaginal dryness
Endometriosis STD's including HPV Fibroids Vaginal infection
Difficulty getting pregnant Pelvic pain Currently pregnant
No menstruation

Menstrual Cycle Information:
How many days do you menstruate? _____ Spotting

before or after period: _____ Clots? Yes/ no _____

Clot Size_____ Number of clots_____

Volume of menstrual blood _____

Color of menstrual blood: bright red maroon brown

MEN'S HEALTH:

Frequent Urination ___ Reproductive Issues ___ Prostate Problems _____
Painful Urination ___ Anything else? _____

VIIII. CURRENT EMOTIONAL STATUS:

Please take a moment to answer the following questions:

Are you able to express your feelings and emotions?

Is there an excess of stress in your life?

What is causing the stress?

Are you satisfied with your job?

If in a relationship, are you satisfied with it?

If there is one thing in your life you would like to change right now, what is it?

Can you change it?

Are you a "nervous type" person?

What are the things that make you most nervous?

Have you a "super woman/superman" complex?

Do you sleep well?_____How long each night?_____

Do you nap?_____ How long and often?_____

Do you dream?_____ Do you remember your dreams?_____

Are you satisfied with your general energy level?_____

Do you often feel exhausted and fatigued?_____

Is it easy to wake up in the morning?_____

Which of these feelings dominate in your life:
joy happiness anger sadness fear sympathy worry depression

If you were to choose two EMOTIONS, which seem predominant in your life, they would be_____and_____.

Past Traumas: sexual, abusive, childhood accidents or physical traumas? Please indicate approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residents, injury, death, etc.)

Year Event

Name one thing in life that you do that is really good for you:_____

_____

Name one thing you know you should be doing but don't:_____

_____

What are your passions and interests?_____

_____

What do you do for fun?

_____