Holistic Health Assessment Initial Intake Form

The Center: Natural Health Specialists
8404 Six Forks Rd. Suite 201 Raleigh, NC 27615
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Patient Name: _____
Age: _____ Birth Date:_____ Sex: _____
Address: _____
City: _____ State: _____ Zip: _____

Telephone (Day): _____
Telephone (Night): _____
Telephone (Mobile): _____

Email Address: _____

Occupation: _____

Main Complaints

Please identify the major health concerns for which you are seeking help in order severity and for how long you have had each problem.

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____
5. _____ How long? _____
6. _____ How long? _____
7. _____ How long? _____
8. _____ How long? _____
9. _____ How long? _____
10. _____ How long? _____

How would you rate the quality of your life (1=very poor, 10=excellent)? _____

To what extent do these problems interfere with your daily activities and effect your quality of life?: _____
What are your health care goals? _____

_____

_____

Have you been given a diagnosis for these problems? _____

_____

What other treatments have you tried and what has been your response? _____

_____

General Information

How did you hear about The Center: Natural Health Specialists? _____

If you were referred to us, by who? _____ Phone: _____

Who is your primary heath care provider/MD? _____ Phone: _____

In an emergency notify: _____ Phone: _____

Personal Medical History (with dates)

Illnesses: _____

_____

_____

Surgeries: _____

_____

Significant Trauma (i.e. motor vehicle accidents, falls, injuries…): _____

_____

Do you or have you ever had any infectious disease? _____ If so please describe: _____

_____

Allergies/Sensitivities: Please list any foods, drugs, medications, or environmental factors which you are sensitive or allergic to: _____

_____

_____

_____

Significant Illnesses:

☐ Cancer	☐ Diabetes	☐ Hepatitis
☐ Thyroid Disease	☐ Seizures	☐ Rheumatic Fever
☐ Heart Disease	☐ Stroke	☐ Addictive Disorders
☐ Food Allergies	☐ Allergies	☐ Respiratory Problems
☐ High Blood Pressure	☐ HIV or AIDS	☐ Mental Illness

☐ Other: _____

_____

_____

Habits & Lifestyle

- How many times per week do you exercise? _____
- How many times per day do have caffeine? _____
- How many soft drinks do you consume in a week? _____
- How many alcoholic drinks do you consume in a week? _____

- How many days per week do you use tobacco? _____
- How many days per week do you consume refined sugar? _____
- How many days per week do you use recreational drugs? _____

- How many times per week do you eat out? _____
  - How many times per week do you eat fast food? _____
  - When you do eat out, where do you typically go? _____
    _____
    _____

- How many days per week do you cook your own food? _____
- What are the three healthiest foods you eat during the average week?
  1) _____
  2) _____
  3) _____

- What are the three worst foods you eat during the average week?
  1) _____
  2) _____
  3) _____

Family Medical History

Check All Applicable	Mother	Father	Sisters	Brothers	Spouse	Children
Current Age	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐
Back pain	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Digestive Disorders	☐	☐	☐	☐	☐	☐
Emotional Problems	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Liver Disorders	☐	☐	☐	☐	☐	☐
Reflux	☐	☐	☐	☐	☐	☐
Stress/Anxiety	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

If any of the above are deceased, what was the cause?: _____

_____

How was your childhood health: _____

_____

General (please check all that apply)

- ☐ Poor Appetite
- ☐ Hearing Loss
- ☐ Easy to Bleed or Bruise
- ☐ Strong Thirst
- ☐ Tremors
- ☐ Night Sweats
- ☐ Changes in Appetite
- ☐ Weakness
- ☐ Fevers
- ☐ Sweat Easily
- ☐ Poor Sleep
- ☐ Poor Balance
- ☐ Cravings
- ☐ Puffiness or Swelling
- ☐ Sudden Energy Drops
- ☐ Particular Tastes or Smells
- ☐ Fatigue
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other: _____

_____

_____

Skin & Hair

- ☐ Rashes
- ☐ Skin Ulcers
- ☐ Hives
- ☐ Changes in Hair
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Fungus
- ☐ Dandruff
- ☐ Dermatitis
- ☐ Recent Moles
- ☐ Herpes

Head, Eyes, Ears, Nose, and Throat

- ☐ Dizziness
- ☐ Cataracts
- ☐ Toothache
- ☐ Headaches
- ☐ Night Blindness
- ☐ Nose Bleeds
- ☐ Migraines
- ☐ Ear Aches
- ☐ Lip or Tongue Sores
- ☐ Glasses
- ☐ Ear Ringing
- ☐ Teeth Problems
- ☐ Concussions
- ☐ Blurry Vision
- ☐ Facial Pain
- ☐ Eye Pain
- ☐ Spots in Front of Eyes
- ☐ Decreased Hearing
- ☐ Poor Vision
- ☐ Sinus Problems
- ☐ Taste/Smell Problems
- ☐ Eye Strain
- ☐ Poor Hearing
- ☐ Jaw Click
- ☐ Color Blindness
- ☐ Recurrent Sore Throat
- ☐ Floaters

Cardiovascular

- ☐ High/Low Blood Pressure
- ☐ Cold Hands or Feet
- ☐ Swelling of Hands
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Swelling of Feet
- ☐ Fainting
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Light Headedness

Respiratory

- ☐ Cough
- ☐ Phlegm
- ☐ Asthma
- ☐ Bronchitis
- ☐ Coughing up Blood
- ☐ Painful Breathing
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Easily Winded

Gastro-Intestinal

- ☐ Nausea
- ☐ Bad Breath
- ☐ Chronic Laxative Use
- ☐ Indigestion
- ☐ Blood in Stools
- ☐ Constipation
- ☐ Ulcers
- ☐ Vomiting
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Intestinal Gas
- ☐ Belching
- ☐ Loss of Appetite

Urology

- ☐ Painful Urination
- ☐ Decrease in Urine Flow
- ☐ Cloudy Urine
- ☐ S.T.D.s
- ☐ Urgency to Urinate
- ☐ Frequent Urine
- ☐ Kidney Stones
- ☐ Pain in Groin Area
- ☐ Unable to Hold Urine
- ☐ Blood in Urine
- ☐ Genital Sores
- ☐ Frequent Night Urination

Neuro-Psychological

- ☐ Seizures
- ☐ Twitches
- ☐ Bad Temper
- ☐ Poor Memory
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Anxiety
- ☐ Concussion
- ☐ Depression
- ☐ Stress
- ☐ Mood Swings

☐ Irritability ☐ Tremors ☐ Dizziness

Gynecology

Age of First Menses: _____
Duration of Menses: _____
Date of Last Menses: _____
# of Pregnancies: _____
# of Births:_____

☐ Irregular Periods
☐ Painful Periods
☐ Breast Lumps
☐ Spotting
☐ Vaginal Discharge

☐ Clots
☐ PMS
☐ Menopausal
☐ Yeast Infections
☐ Fertility Problems

Musculo-Skeletal

☐ Arthritis
☐ Muscle Weakness
☐ Muscle Cramping
☐ Muscle Spasms
☐ Scoliosis
☐ Weak Joints
☐ Vertebral Disk Disorders- Bulging, Herniated, Ruptured
☐ Sprains/Strains
☐ Broken Bones

Please circle any areas of pain or discomfort: (Indicate description and severity)

Metabolic Assessment

Please select the appropriate number on all questions below. 0 as the least/never to 3 as the most/always

Category I	0 1 2 3
Feeling that bowels do not empty completely	☐☐☐☐
Lower abdominal pain relieved by passing stool or gas	☐☐☐☐
Alternating constipation and diarrhea	☐☐☐☐
Diarrhea	☐☐☐☐
Constipation	☐☐☐☐
Hard, dry, or small stool	☐☐☐☐
Coated tongue or "fuzzy" debris on tongue	☐☐☐☐
Pass large amount of foul-smelling gas	☐☐☐☐
More than 3 bowel movements daily	☐☐☐☐
Use laxatives frequently	☐☐☐☐
Category II	0 1 2 3
Increasing frequency of food reactions	☐☐☐☐
Unpredictable food reactions	☐☐☐☐
Aches, pains, and swelling throughout the body	☐☐☐☐
Unpredictable abdominal swelling	☐☐☐☐
Frequent bloating and distention after eating Abdominal intolerance to sugars and starches	☐☐☐☐
Category III	0 1 2 3
Intolerance to smells	☐☐☐☐
Intolerance to jewelry	☐☐☐☐
Intolerance to shampoo, lotion, detergents, etc	☐☐☐☐
Multiple smell and chemical sensitivities	☐☐☐☐
Constant skin outbreaks	☐☐☐☐
Category IV	☐☐☐☐
Excessive belching, burping, or bloating	☐☐☐☐
Gas immediately following a meal	☐☐☐☐
Offensive breath	☐☐☐☐
Difficult bowel movements	☐☐☐☐
Sense of fullness during and after meals	☐☐☐☐

Category IV	0 1 2 3
Excessive belching, burping, or bloating	☐☐☐☐
Gas immediately following a meal	☐☐☐☐
Offensive breath	☐☐☐☐
Difficult bowel movements	☐☐☐☐
Sense of fullness during and after meals	☐☐☐☐
Difficulty digesting fruits and vegetables;	☐☐☐☐
undigested food found in stools	☐☐☐☐
Category V	0 1 2 3
Stomach pain, burning, or aching 1-4 hours after eating	☐☐☐☐
Use of antacids	☐☐☐☐
Feel hungry an hour or two after eating	☐☐☐☐
Heartburn when lying down or bending forward	☐☐☐☐
Temporary relief by using antacids, food, milk, or carbonated beverages	☐☐☐☐
Digestive problems subside with rest and relaxation	☐☐☐☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	☐☐☐☐
Category VI	0 1 2 3
Roughage and fiber cause constipation	☐☐☐☐
Indigestion and fullness last 2-4 hours after eating	☐☐☐☐
Pain, tenderness, soreness on left side under rib cage	☐☐☐☐
Excessive passage of gas	☐☐☐☐
Nausea and/or vomiting	☐☐☐☐
Stool undigested, foul smelling, mucus like,	☐☐☐☐
greasy, or poorly formed	☐☐☐☐
Frequent urination	☐☐☐☐
Increased thirst and appetite	☐☐☐☐

Metabolic Assessment Continued

Category VII	0 1 2 3
Abdominal distention after consumption of fiber, starches, and sugar	☐☐☐☐
Abdominal distention after certain probiotic or natural supplements	☐☐☐☐
Lowered gastrointestinal motility, constipation	☐☐☐☐
Raised gastrointestinal motility, diarrhea	☐☐☐☐
Alternating constipation and diarrhea	☐☐☐☐
Suspicion of nutritional malabsorption	☐☐☐☐
Frequent use of antacid medication	☐☐☐☐
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	☐☐☐☐
Category VIII	0 1 2 3
Greasy or high-fat foods cause distress	☐☐☐☐
Lower bowel gas and/or bloating several hours after eating	☐☐☐☐
Bitter metallic taste in mouth, especially in the morning	☐☐☐☐
Burpy, fishy taste after consuming fish oils	☐☐☐☐
Difficulty losing weight	☐☐☐☐
Unexplained itchy skin	☐☐☐☐
Yellowish cast to eyes	☐☐☐☐
Stool color alternates from clay colored to normal brown	☐☐☐☐
Reddened skin, especially palms	☐☐☐☐
Dry or flaky skin and/or hair	☐☐☐☐
History of gallbladder attacks or stones	☐☐☐☐
Have you had your gallbladder removed?	☐☐☐☐
Category IX	0 1 2 3
Acne and unhealthy skin	☐☐☐☐
Excessive hair loss	☐☐☐☐
Overall sense of bloating	☐☐☐☐
Bodily swelling for no reason	☐☐☐☐
Hormone imbalances	☐☐☐☐

Category IX (Continued)	0 1 2 3
Weight gain	☐☐☐☐
Poor bowel function	☐☐☐☐
Excessively foul-smelling sweat	☐☐☐☐
Category X	0 1 2 3
Crave sweets during the day	☐☐☐☐
Irritable if meals are missed	☐☐☐☐
Depend on coffee to keep going/get started	☐☐☐☐
Get light-headed if meals are missed	☐☐☐☐
Eating relieves fatigue	☐☐☐☐
Feel shaky, jittery, or have tremors	☐☐☐☐
Agitated, easily upset, nervous	☐☐☐☐
Poor memory/forgetful	☐☐☐☐
Blurred vision	☐☐☐☐
Category XI	0 1 2 3
Fatigue after meals	☐☐☐☐
Crave sweets during the day	☐☐☐☐
Eating sweets does not relieve cravings for sugar	☐☐☐☐
Must have sweets after meals	☐☐☐☐
Waist girth is equal or larger than hip girth	☐☐☐☐
Frequent urination	☐☐☐☐
Increased thirst and appetite	☐☐☐☐
Difficulty losing weight	☐☐☐☐
Category XII	0 1 2 3
Cannot stay asleep	☐☐☐☐
Crave salt	☐☐☐☐
Slow starter in the morning	☐☐☐☐
Afternoon fatigue	☐☐☐☐
Dizziness when standing up quickly	☐☐☐☐
Afternoon headaches	☐☐☐☐
Headaches with exertion or stress	☐☐☐☐
Weak nails	☐☐☐☐

Metabolic Assessment Continued

Category XIII	0 1 2 3
Cannot fall asleep	☐☐☐☐
Perspire easily	☐☐☐☐
Under a high amount of stress	☐☐☐☐
Weight gain when under stress	☐☐☐☐
Wake up tired even after 6 +hours of sleep	☐☐☐☐
Excessive perspiration or perspiration with little or no activity	☐☐☐☐
Category XIV	0 1 2 3
Edema and swelling in ankles and wrists	☐☐☐☐
Muscle cramping	☐☐☐☐
Poor muscle endurance	☐☐☐☐
Frequent urination	☐☐☐☐
Frequent thirst	☐☐☐☐
Crave salt	☐☐☐☐
Abnormal sweating from minimal activity	☐☐☐☒
Alteration in bowel regularity	☐☐☐☐
Inability to hold breath for long periods	☐☐☐☐
Shallow, rapid breathing	☐☐☐☐
Category XV	0 1 2 3
Tired/sluggish	☐☐☐☐
Feel cold—hands, feet, all over	☐☐☐☐
Require excessive amounts of sleep to function properly	☐☐☐☐
Increase in weight even with low-calorie diet	☐☐☐☐
Gain weight easily	☐☐☐☐
Difficult, infrequent bowel movements	☐☐☐☐
Depression/lack of motivation	☐☐☐☐
Category XVI	0 1 2 3
Heart palpitations	☐☐☐☐
Increased pulse even at rest	☐☐☐☐
Nervous and emotional	☐☐☐☐
Insomnia	☐☐☐☐
Night sweats	☐☐☐☐
Difficulty gaining weight	☐☐☐☐

Category XVII (Males Only)	0 1 2 3
Urination difficulty or dribbling	☐☐☐☐
Frequent urination	☐☐☐☐
Pain inside of legs or heels	☐☐☐☐
Feeling of incomplete bowel emptying	☐☐☐☐
Leg twitching at night	☐☐☐☐
Category XVIII (Males Only)	0 1 2 3
Decreased libido	☐☐☐☐
Decreased number of spontaneous morning erections	☐☐☐☐
Decreased fullness of erections	☐☐☐☐
Difficulty maintaining morning erections	☐☐☐☐
Spells of mental fatigue	☐☐☐☐
Inability to concentrate	☐☐☐☐
Episodes of depression	☐☐☐☐
Muscle soreness	☐☐☐☐
Decreased physical stamina	☐☐☐☐
Unexplained weight gain	☐☐☐☐
Increase in fat distribution around chest and hips	☐☐☐☐
Sweating attacks	☐☐☐☐
More emotional than in the past	☐☐☐☐
Category XIX (Menstruating Females Only)	0 1 2 3
Perimenopausal	☐☐☐☐
Alternating menstrual cycle lengths	☐☐☐☐
Extended menstrual cycle (greater than 32 days)	☐☐☐☐
Shortened menstrual cycle (less than 24 days)	☐☐☐☐
Pain and cramping during periods	☐☐☐☐
Scanty blood flow	☐☐☐☐
Heavy blood flow	☐☐☐☐
Breast pain and swelling during menses	☐☐☐☐
Pelvic pain during menses	☐☐☐☐
Irritable and depressed during menses	☐☐☐☐
Acne	☐☐☐☐
Facial hair growth	☐☐☐☐
Hair loss/thinning	☐☐☐☐

Metabolic Assessment Continued

Category XX (Menopausal Females Only)	
How many years have you been menopausal?	0 1 2 3
Since menopause, do you ever have uterine bleeding?	☐☐☐☐
Hot flashes	☐☐☐☐
Mental fogginess	☐☐☐☐
Disinterest in sex	☐☐☐☐
Mood swings	☐☐☐☐
Depression	☐☐☐☐
Painful intercourse	☐☐☐☐
Shrinking breasts	☐☐☐☐
Facial hair growth	☐☐☐☐
Acne	☐☐☐☐
Increased vaginal pain, dryness, or itching	☐☐☐☐

Additional Information

Please let us know if there anything else influencing the quality of your life that has not been addressed in this document.