Holistic Healthcare of Virginia

Client Health Questionnaire

Part 1

Date: ____________,

Name: ____,

Male ( ) Female ( ) D.O.B_____________ Age ______Cultural Heritage ______________________

Height ________Weight ________Has your height or weight changed in recent months/years?_____

Are you currently under any medical/therapeutic treatment? ___Yes ___No
If so, for what condition? ____,
____,
Please list the name and phone # of the person providing the care: ______________,
____,
Permission to Consult with this person? ___No ___Yes (Please Initial) _______________

Blood Pressure

Which of the following best describes your blood pressure tendency at the present time irrespective of any medications that you might be on? For example, if your blood pressure is normal because you are taking medicine for high blood pressure, check the High Blood Pressure option.

High Blood Pressure or Hypertension
Borderline high
About normal
Tends to run below normal
Low Blood Pressure
I have no idea of what my blood pressure is.

Prescription Drugs

Check all of the following prescription drugs that you commonly **or** currently use:

Prescription drug for ADD or ADHD (e.g., Ritalin, Methylin, Methylphenidate, etc.)
Prescription thyroid hormone (e.g., Synthroid, Levothyroxine, etc.)
Prescription antibiotic (e.g., Trimox, Amoxicillin, Zithromax, Azithromycin, etc.)
Prescription pain medication (e.g., Lortab, Vicodin, Anexsia, Hydrocodone, etc.)
Prescription drug for depression (e.g, Prozac, Fluoxetine, Zoloft, Sertraline, Paxil, Paroxetine, etc.)
Prescription or OTC antacid (e.g, Prilosec, Omeprazole, Prilosec OTC, etc.)
Cholesterol drug (e.g., Lipitor, Atorvastatin, etc.)
Prescription hypertesnion or high blood pressure drug (e.g., Norvasc, Amlodipine, etc.)
Prescription antihistamine (e.g., Claritin, Loratadine, etc.)
Prescription heart drug (e.g., Lanoxin, Digoxin, etc.)
Prescription blood thinner (e.g., Coumadin, Warfarin, etc.)
Other prescription drug(s) not mentioned above

List any other medications (including over-the-counter) and vitamin, mineral, and/or herbal supplements you are taking and what they are for (e.g., hawthorn as a cardiac support):
____,

Any Known Allergies? ____,

Has there been a medical diagnosis? ___Yes ___No
If so, by whom? ____,
Please explain: ____,
____,

Overall physical condition: Poor _____ Fair_____ Good_____ Excellent_____

Major life changes in past year:(new job, baby, death in family, divorce, child leaving home, retirement)

Health habits: Exercise beyond normal daily activities and chores? No •Yes •Describe the exercise, including how often, how long

____

Medical History: Check or circle those that apply to you now or in the past.

___Allergies/Asthma
___Emphysema/C.O.P.D.
___Other Lung Problems
___Heart Problems
___High Blood Pressure
___Angina
___Heart Murmurs
___Mitral Valve Prolapse
___Blood Clots/Phlebitis
___Other Circulation Disorders
___Stroke/TIA
___Diabetes
___Cancer Type_________
___Seizures/Epilepsy
___Head Injury
___Multiple Sclerosis
___Parkinson's
___Essential Tremor
___Headaches/Migraines
___Other Neurological Problems
___Depression
___Anxiety
___Psychiatric Disorders
___Vision Disorders
___Hearing Disorders
___Kidney Problems
___Urinary/Bladder Control
___Digestive Disorders
___GERD
___Ulcers
___Bowel Problems
___Infectious Diseases
___TB
___Hepatitis
___HIV/AIDS
___Other
___Thyroid Problems
___Skin Problems
___Arthritis
___Tendonitis
___Bursitis
___Back Problems
___Scoliosis
___Knee Problems
___Hip Problems
___Hernia
___Broken Bone(s)
___Fibromyalgia
___Osteopenia
___Osteoporosis

Explain any items you have checked above:

____

____

List any orthopedic (bones, tendons, ligaments, muscles, cartilage, joints) injuries or problems you have experienced for which you have had treatment, surgery, medication or physical therapy:

____

____

List and give approximate year of any other major illnesses, conditions, surgeries or accidents you have experienced:

____

____

Within the past year, have you had any of the following medical tests?(check all that apply)

___Angiogram
___MRI
___Biopsy
___Blood Tests
___Bone Scan
___Bronchoscopy
___Pulmonary Function Tests
___CT Scan
___EKG
___Cardiac Stress Test
___Myelogram
___Nerve Conduction Velocity
___Electromyogram
___Arthroscopy
___EEG
___Bone Density Test
___Urine Flow Studies
___Cystoscopy
___Pap Smear
___Mammogram

If other than routine test, please explain:

____

____

Is there any health-related reason why you should not participate in an exercise program?

____

____

Smoker? Yes ___ No ___ Alcohol Use:____

If you have any special needs to be considered prior to or during treatment please explain:

____

Part II

What would you like to get out of today's session/this program?

____

____

What is your primary issue or reason for coming today?

____

____

When/how did it begin?

____

____

Have you had this problem before? _______________If so, when?______________________

What did you do for it?____

____

Did the problem(s)get better? _______________ How long did it last?___________________

What treatments/diagnostic tests have you received for this problem?
___None ___Surgery ___injections ___Splint/Brace ___X-rays ___MRI
___CT Scan___ Chiropractic Care ___Massage Therapy ___Physical Therapy
___Medications (prescription and nonprescription) _________________________________
____
Other____

How are you managing the problem now?

____

What activities are you not able to do that you could do before the problem Be as specific as you can.

Example: unable to reach above your head.

____

____

What makes the problem worse?

____

____

What makes the problem better?

____

When are your symptoms most severe? ___AM ___PM ___Consistent all day

Are your symptoms affecting your ability to work or otherwise be active?
If so, how?

____

Current Limitations:(check all that apply):

Difficulty with movement? ___
Getting in/out of bed or up/down from a chair?___
Changing positions in bed ? ___
Difficulty with grooming and bathing?___
Walking: level ___stairs ___ramps ___uneven terrain ____
Difficulty with home management (household chores, yard work, driving, shopping):___
Difficulty with community and work activities (work, school, play, recreation) ___

Since this issue began is the pain:
___Increased ___Decreased ___Not Changing ___Constant ___Intermittent

Rate your pain with 0 being no pain and 10 being the worst pain: (please circle)

Pain now	0 1 2 3 4 5 6 7 8 9 10
Best day	0 1 2 3 4 5 6 7 8 9 10
Worst day	0 1 2 3 4 5 6 7 8 9 10

Do you have any other significant issues?

____

____

____

Your goals: What concerns you most (please prioritize issues if you have more than one)? What do you hope to gain from this program and what is your time-line for achieving this goal?

____

At Holistice Healthcare of Virginia we look at the whole body•mind•spirit. Do you feel there is any emotional or spiritual component that may be part of the issue? (e.g., death in family at around same time as symptoms showed, job loss at same time as symptoms showed, relationship issues around the same time, etc.)

Please describe any spiritual concerns you may have and if you are interested in beginning or deepening your meditation practice or beginning or deepening your breathing practice.

Ayurvedic Assessment

For each of the following observations (left column), please choose the description from one of the three other columns (V, P, or K) that best describes yourself today.

Observation	V	P	K
Body size	slim	medium	large
Body weight	low	medium	overweight
Skin	thin, dry, cold, rough, dark	smooth, oily, warm, rosy	thick, oily, cool, white, fair
Hair	dry, brown, black, knotted, brittle, thin	straight, oily, blond, gray, red, bald	thick, curly, oily, wavy, luxuriant, all colors
Teeth	Protruding, big, roomy, thin gums	medium, soft, tender gums	health, white, strong gums
Nose	uneven shape, deviated septum	long pointed, red nose-tip	short rounded, button nose
Eyes	small, sunken, dry, active, black, brown, nervous	sharp, bright, gray, green, yell/red, sensitive to light	big, beautiful, blue, calm, loving
Nails	dry, rough, brittle, break easily	sharp, flexible, pink, lustrous	thick, oily, smooth, polished
Lips	dry, cracked, black/brown tinged	red, inflamed, yellowish	smooth, oily, pale, whitish
Chin	thin, angular	tapering	rounded, double
Cheeks	sunken	smooth, flat	rounded, plump
Neck	thin, tall	medium	big, folded
Chest	flat, sunken	moderate	expanded, round
Belly	thin, flat, tight	moderate	big, potbellied
Belly button	small, irregular, herniated	oval, superficial	big, deep, round, stretched
Hips	slender, thin	moderate	heavy, big
Joints	cold, cracking	moderate	large, lubricated
Appetite	irregular, scanty	Strong, voracious	slow but steady
Digestion	irregular, forms gas	quick, causes burning	prolonged, forms mucus
Taste, healthy preference	sweet, sour, salty	sweet, bitter, astringent	bitter, pungent, astringent
Thirst	changeable	surplus	sparse
Elimination	constipation	loose	thick, oily, sluggish
Physical activty	hyperactive	moderate	sedentary
Mental activity	always active	moderate	dull, slow
Emotions	anxiety, fear, uncertainty, flexible	anger, hate, jealousy, determined	calm, greedy, attachment
Faith	variable, changeable	intense, extremist	consistent, deep, mellow
Intellect	quick, but faulty response	accurate response	slow, exact
Recollection	recent good, remote poor	distinct	slow and sustained
Dreams	quick, active, many, fearful	fiery, war, violence	lakes, snow, romantic
Sleep	scanty, broken up, sleeplessness	little but sound	deep, prolonged
Speech	rapid, unclear	sharp, penetrating	slow, monotonous
Financial	poor, spends on trifles	spends money on luxuries	rich, good money preserver

If you have any other comments that may be helpful, please feel free to use this space.

To the best of my abilities I acknowledge that I have given a complete and accurate picture of my health. My signature below attests to this statement. Further, I acknowledge that I am embarking on my own healing journey with the aid of the Practitioner from Holistic Healthcare of Virginia and I take responsibility for my own decisions, will use my Primary Care Physician for advice about medications, and/or drug interactions with any supplements, herbs, vitamins that may be suggested. I also give permission of the Practitioner from Holistic Healthcare of Virginia to take my pulses Ayurvedically (reading elements on both wrists for the overall health of the organ systems and body).