New Client Questionnaire – For Holistic Assessment

Steve Byers, Clinical Herbalist

Hello! Please answer the questions below as much as you feel able and comfortable to.
Please allow ~ 15-20 minutes to complete this form. Your words are valued!

Your Name_____ Today's Date _____
Address_____
Telephone _____ Email:_____
Best way to contact you:_____
For Astrology (if you know) Date of Birth _____Birthplace and time of day _____
Age_____

What are your primary goals for your health?
1._____
2._____
3._____
What other health-related issues do you currently have or have you had in the past?
_____
_____
_____

Please list any other practitioners you are currently working with.
_____

BODY/MIND/SPIRIT
What mental and spiritual practices do you rely on for supporting your healing journey?_____
_____

Medications currently or previously used (over the counter and prescription):
Please feel free to attach a separate list or continue on the back if you are taking more medications than the space available permits you to list.

Medication	**Dosage/Frequency/Taking how long?**	**For what reason are you taking this?**

History of Antibiotic Use: # of times used in the last 10 years_____
Any long periods of antibiotic use? (>2 wks.) When? _____ Used 2+ times as a child? Yes / No

Supplements/vitamins/herbs currently used:

Supplement (include brand)	**Dosage/Frequency/Taking how long?**	**For what reason are you taking this?**

Family Health History: Please describe any **relevant** or major health-related issues with your immediate family members and/or grandparents:

_____

DIET:

What are the top 5 foods you eat on a weekly basis? **1.** _____**2.**_____
3._____**4.** _____**5.**_____
Are you **satisfied** with your diet? What would you change**?**

_____

_____

How often do you eat at restaurants? _____
How often do you cook/prepare food? _____ Meals eaten per day?

_____
What foods/flavors do you crave?

_____
Do you follow or have you ever followed a restricted diet? Which one(s)?

_____
Do you have any **Allergies???** (medications, pollens, foods)? _____

_____
Do you have any **food sensitivities** to: Gluten__ Dairy__ Nuts __ (Nightshades) __ Mushrooms __ Other_____
Water consumption (average # of cups/day): _____ Is it chlorinated? _____ Filtered? _____

Health History

Please check any of the below symptoms or diseases you have experienced. Use a scale of 1-5, 1 the least and, 5 being the most severe. If unsure, use a question mark '?'. LEAVE BLANK THOSE THAT DON'T APPLY.

____ADD/ADHD ____Alcoholism ____Allergies ____Anemia ____Anxiety ____Arthritis ____Asthma ____Bloating ____Cancer ____Cavity/Mercury Fillings ____Chemical sensitivities ____Chronic fatigue ____Constipation ____Depression ____Diabetes ____Diarrhea ____Dizziness ____Drug abuse ____Environmental sensitivities ____Epilepsy	____Epstein-Barr virus ____Excess stress ____Eyesight problems ____Fatigue ____Gynecological problems ____Heartburn ____Headaches ____Hearing problems ____Heart disease ____Hepatitis ____High blood pressure ____HIV/AIDS ____Hyperglycemia ____Hypoglycemia ____Immune disorders ____Injuries ____IBS/IBD ____Low blood pressure ____Lyme Disease ____Male health problems	____Memory loss ____Menopause problems ____Menstrual irregularities ____Numbness ____Painful joints ____Parasites/Amoeba ____Rashes ____Respiratory problems ____Root Canals ____Seizures ____Shingles ____I am sick often ____Shortness of breath ____Sleep problems ____Sore throats ____Stiffness ____Stomach aches ____Swelling ____Tumors ____Urinary tract infections

GENERAL QUESTIONS:
Occupation _____ How long? _____ Previous occupations:

_____

Where and when have you lived or traveled outside the U.S. and Canada?

_____

_____

What are your hobbies/interests?

_____

What is your relationship status: _____ Is there anything you would change about your relationship or support system so that it could better benefit your health? What would that be?

_____

Body Temperature: What is your favorite temperature range? _____

Please write 'H' for Hot and 'C' for Cold, if applicable to these body areas

____General body ____Arms ____Hands	____Palms ____Fingers ____Legs	____Feet ____Pelvic region ____Head	____Chest ____Stomach Other_____

FEMALE BODY REPRODUCTIVE HEALTH HISTORY

Thank you for being specific and clear in this section. Understanding the root cause of health concerns is best understood when specific details are provided.

Write a **'P' for past condition** and a **check** for any current conditions.

General

____Breast pain ____Cervical dysplasia ____Cysts ____Endometriosis ____Fibroids	____Infertility ____Miscarriage ____Painful intercourse ____Pelvic inflammatory disease (PID)	____STDs ____Tumors ____Unusual PAP ____Vaginal discharge	____Vaginal dryness ____Vaginal infection ____Vaginitis Other_____

Menstrual Cycle

____Acne /skin rash ____Bleeding between cycles ____Mood swings	____Cramps (stomach, pelvis) ____Bloating (stomach, hands, feet) ____Irregular cycle	____Painful menses ____Pain with ovulation ____Other _____

Average number of days bleeding _____? Approximately how many days between menses, is the time period the same from month to month?

_____

What helps you feel better during your menstrual cycle?

_____

Sleep:

Are you satisfied with your current sleep? _____

Typical bedtime _____ **Typical hours asleep** _____ Do you feel rested upon waking?

_____

Do you snore?_____ Have pet allergies? _____ Mold in home? (or suspect it)

_____

Are you often using screens (phone/computer/ipad) 2 hrs. before you go to bed?

_____

Bowel Movements: (Please be specific- this gives important info about your digestive function)

-How many bowel movements do you have a day or week?_____

-Please circle the words below which best describe your average stool color and shape:

1.COLOR: dark brown brown light brown cream colored pale yellow
2.SHAPE: liquid soft/unformed soft/formed pellets hard/ solid other_____

Stress

On a scale from 1 (low) to 10 (high):
How stressful is your: Work? ____ Health status? _____ Social/family situation? _____
What are your **energy levels** like an on average day (1-10)? _____
Please circle the dominant emotions in your life right now: joy, worry, satisfaction, anger, fear, grief, content, inspiration, other_____
Do you get headaches? How often?_____ Are they dull & throbbing OR tense & constrictive? (tight band)
Do you Smoke? _____ How many cigarettes per day?
_____
Do you drink alcohol? _____ How many drinks per day or week?
_____

Trauma/Shocks to your Being: (Please share only as your are comfortable)

Have you had any **surgeries**? _____ For what reason(s)?
_____
Have you had any **organs/tissues removed** (tonsils/gallbladder/uterus)?
_____
Have you had lengthy exposure to environmental toxins (work w/chemicals? home near polluted area)?
_____
Have you ever been very sick from a parasite? Ameoba? Food Poisoning?
_____
Do you have a history of substance abuse in your life (yourself/family/friends)?
_____
_____
Have you been sexually abused? _____
If yes, is this something you would like to address in this consultation or future consultations?
_____

Life Timeline

Please **list major events** in the last ten years of your life (or **further back if it seems significant**) and the dates they occurred. Include events such as births, deaths, marriages, divorces, accidents, trauma/abuse, moves, jobs changes, miscarriages, illnesses and anything else you feel greatly impacted your life.

Date **Event**

Anything additional that you'd like to mention related to health and well-being:

THANK YOU! The time and effort you have taken to provide this detailed information will be very important to informing and complimenting our work together and your journey towards better health.

Please take a moment to relax and smile. Breathe deeply and indentify the best intentions you have for your health. I look forward to meeting with you soon!

Contact me with any questions: (207)-205-2515