

## Holistic Assessment

Name: \_\_\_\_\_ Nickname (preferred to be called) \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ c or h

\_\_\_\_\_ Best Way to contact you? \_\_\_\_\_

Emergency contact: (name and number) \_\_\_\_\_

How did you hear about this? \_\_\_\_\_

Reason for coming today? \_\_\_\_\_

\_\_\_\_\_

Other Healthcare providers: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication (prescribed): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication (OTC): \_\_\_\_\_

\_\_\_\_\_

Other Supplements: \_\_\_\_\_

\_\_\_\_\_

Any ongoing medical treatments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any on going alternative treatments (massage therapy, physical therapy, acupuncture,

Energy work, etc): \_\_\_\_\_

\_\_\_\_\_

## Holistic Assessment

Past medical history: (including childhood diseases) \_\_\_\_\_

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Past surgeries and when: \_\_\_\_\_

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Past hospitalizations and when: \_\_\_\_\_

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Current medical diagnosis: \_\_\_\_\_

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When first diagnose by whom, current treatment? By whom? \_\_\_\_\_

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Any current physical problems: please circle or answer

Breathing (shortness of breath, difficulty breathing etc) , Blood pressure (high or low),

Palpitations, Sweating, Hot flashes,( Pre menopausal, menopausal, post menopausal)

Age at onset of menses (period) PMS

Using birth control, trying to get pregnant, sexually active, NA

Number of pregnancies births abortions miscarriages

Excessive Bleeding, Bruising easily,

Pain (Where?)

Muscles, Bones, Skin, Bladder/ kidney/ urinary tract, Seizures, Headaches, Vision

Hearing, Tasting , Smelling, Stomach/digestion, Bowels, Diarrhea, Constipation

Sleep: too much too little difficulty falling asleep difficulty staying asleep



## Holistic Assessment

Who are you emotional and life support systems?

Current living arrangements:

Current working environment:

Previous occupations:

Highest level of education:

Legal history: felony charges misdemeanor charges lawsuits file or filed against you?

Witness any domestic violence?

Filed any charges of DV?

Been charge with any DV charges?

Other trauma history?

Any verbal abuse to you: by whom?

to others?

Any physical abuse to you: by whom?

to others?

Any sexual abuse to you:

to others:

Ever been in the military? Doing what?

For how long?

Honorable discharge? Yes no When?

Are your parents alive?

If not how old were they when they died and what did they die of:

Did they have any significant health history?

How many siblings do you have? Older or younger? Alive? Health issues?

Sisters

Brothers

Half sisters

Half brothers

Step sisters

Step brother

## Holistic Assessment

Do you have step parents?

Can you pick one word to describe each of your parents and or step parents

Can you pick one word or a phrase to describe your childhood

How many children do you have? Their ages? And any significant health concerns?

How many long term relationships have you been in, long have they lasted and why did each ended (In a word or two)

When do you feel the best about yourself?

What do you feel when you first wake up?

What do you generally feel at the end of the day?

Best part of any given day

Worst part of any given day

Best part of life now

Worst part of life now

## Holistic Assessment

Best part of your past was?

Worst part of your past was?

Best thing you look forward to in the future

Worst thing you look forward to

Do you have a religious affiliation?

Do you participate in religious activities?

What are the stressors in your life at this time?

What is your biggest regret in your life?

Is there something you continually feel guilty about?

What is the biggest loss you have experienced in your life

What is the Best gift life has given you?

One thing you would like to fix or begin working on:



## Holistic Assessment

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