Holistic Health and Wellness Center

201 King of Prussia Road, Suite 650, Radnor, PA 19087 | 610-679-4213 | humaira@holistichealthwellnesscenter.com

Today's Date: _____

Name (First)_____ (Last) _____

Address _____**City**_____ **State** _____ **Zip** _____

Gender _____ **Date of Birth** _____

Relationship Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Emergency Contact _____ Language **preference** ☐ English ☐ Spanish ☐ Other: _____

Ethnicity (Italian, Polish, Irish, etc.): _____

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Middle Eastern ☐ Pacific Islander ☐ Native American

Home Phone# _____ **Work/Cell Phone#** (please circle one) _____

Email Address: _____ **Contact Preference** (email, cell etc.) _____

Your Occupation _____Employer_____

Address _____

City _____ State _____ Zip _____

Your Height: ____ feet: ___ inches Weight: _____lbs.

Do you smoke? ☐ Yes☐ No

If you do or have ever smoked: How much? _____ How long? _____

Have you quit? _____ If yes, when? _____ If not, would you like to? _____

Alcohol intake? ☐ Yes☐ No If yes: (type, amount, frequency) _____

Have you been hospitalized during the past year? ☐ Yes☐ No

Number of Pregnancies: _____ Miscarriages: _____

Please describe your pregnancies (full-term, complications, vaginal births…):

_____

Children's ages: _____

Premenstrual/Menopause Symptoms: Date of last menses: _____ Average cycle length: _____

☐Fatigue ☐Depressed ☐ Emotional ☐ Cravings ☐Weight gain
☐Acne ☐Headaches ☐ Hot flashes ☐ Moody ☐ Other

INFANT HISTORY: Type of birth_____ Breastfed_____ Formula Fed_____

Have you ever had frequent or prolonged use of the following drugs? If so, how long?

Steroids_____ Cortisone_____ Prednisone_____ Antibodies_____ Antihistamines_____

Holistic Health and Wellness Center

201 King of Prussia Road, Suite 650, Radnor, PA 19087 | 610-679-4213 | humaira@holistichealthwellnesscenter.com

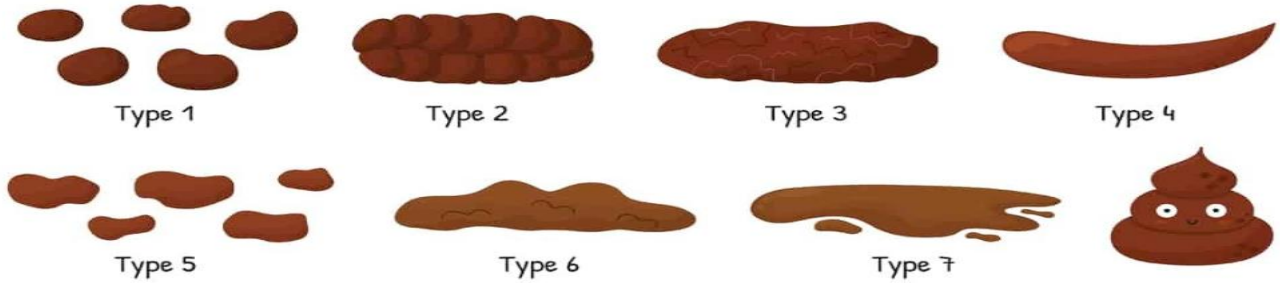
Bowel movement information:

Frequency: ☐ More than 3x / day ☐ 1 – 3x / day ☐ 4 – 6x / week ☐ 2 - 3x / week ☐ 1 or fewer x / week

Color: ☐ Medium brown ☐ Very dark or black ☐ Greenish color ☐ Blood is visible ☐ Varies a lot
☐ Dark brown ☐ Yellow, light brown ☐ Greasy, shiny appearance

Consistency: ☐ Soft and well formed ☐ Often Float □ Difficult to pass ☐ Diarrhea ☐ Thin, long
☐ Small and Hard □ Loose but not watery ☐ Alternating between hard and loose / watery

Select your Stool Type:



Health and medical history:

Current Medications (include prescription and over the counter

Medication	Dosage	Start Date	Reason to use

Nutritional supplements (vitamins/minerals/herbs etc.,)

Medication	Dosage	Start Date	Reason to use

Allergies to any medications: _____

MAIN COMPLAINTS:

COMPLAINT	How Long?	How Worst? 1-10, 10 = Worst

Holistic Health and Wellness Center

201 King of Prussia Road, Suite 650, Radnor, PA 19087 | 610-679-4213 | humaira@holistichealthwellnesscenter.com

Have you had or currently have any of the following conditions?

Gastrointestinal
ϒ Irritable Bowel Syndrome
ϒ Inflammatory Bowel Disease
ϒ Crohn's
ϒ Ulcerative Colitis
ϒ Gastritis or Peptic Ulcer Disease
ϒ GERD (reflux)
ϒ Celiac Disease
ϒ Other _____

Cardiovascular
ϒ Heart Attack
ϒ Stroke
ϒ Elevated Cholesterol
ϒ Hypertension (high blood pressure)
ϒ Other _____

Metabolic/Endocrine
ϒ Type 1 Diabetes
ϒ Type 2 Diabetes
ϒ Hypoglycemia
ϒ Metabolic Syndrome
ϒ Hypothyroidism
ϒ Hyperthyroidism
ϒ Endocrine Problems
ϒ Infertility
ϒ Weight Gain
ϒ Weight Loss
ϒ Frequent Weight Fluctuations
ϒ Bulimia
ϒ Anorexia
ϒ Eating Disorder (non-specific)
ϒ Other _____

Cancer
ϒ Lung Cancer
ϒ Breast Cancer
ϒ Colon Cancer
ϒ Ovarian Cancer
ϒ Prostate Cancer
ϒ Skin Cancer
ϒ Other _____

Genital and Urinary Systems
ϒ Kidney Stones ϒ Gout
ϒ Frequent Yeast Infections
ϒ Erectile or Sexual Dysfunction
ϒ Frequent Urination
ϒ Difficulty Urinating
ϒ Difficulty with erection
ϒ Loss of libido
ϒ Prostate enlargement
ϒ Incontinence
ϒ PMS
ϒ Pain Between Cycles
ϒ Ovarian Cysts
ϒ Irregular periods
ϒ Endometriosis
ϒ Menopause
ϒ Pain During Intercourse
ϒ Painful periods □ Loss of periods
ϒ Birth control pills
ϒ Cervical Dysplasia
ϒ Fibrocystic breasts

Musculoskeletal/Pain
ϒ Osteoporosis/Osteopenia
ϒ Scoliosis
ϒ Muscle Pain
ϒ Arm Numb/Tingling
ϒ Leg Numb/Tingling

ϒ Neck Pain
ϒ Middle Back Pain
ϒ Low Back Pain
□ Shoulder Pain
□ Elbow Pain
□ Hand/Wrist Pain
□ Hip Pain
□ Knee Pain
□ Ankle/Foot Pain
ϒ Joint Pain _____
ϒ Other _____

Inflammatory/Autoimmune
ϒ Chronic Fatigue Syndrome
ϒ Autoimmune Disease
ϒ Rheumatoid Arthritis
ϒ Lupus SLE
ϒ Immune Deficiency Disease
ϒ Poor Immune Function (Frequent Infections)
ϒ Food Allergies
ϒ Environmental Allergies
ϒ Multiple Chemical Sensitivities
ϒ Latex Allergy
ϒ Other _____

Respiratory Diseases
ϒ Asthma
ϒ Chronic Sinusitis
ϒ Bronchitis
ϒ Emphysema
ϒ Pneumonia
ϒ Tuberculosis
ϒ Sleep Apnea
ϒ Other _____

Skin Diseases
ϒ Eczema
ϒ Psoriasis
ϒ Acne
ϒ Melanoma
ϒ Skin Cancer: Type _____

Neurologic/Mood
ϒ Depression
ϒ Anxiety
ϒ Bipolar Disorder
ϒ Headaches
ϒ Migraines
ϒ ADD/ADHD
ϒ Memory Problems
ϒ Parkinson's Disease

ϒ Multiple Sclerosis
ϒ Other Neurological Problems
_____

Preventative Tests and Date of Last Test
ϒ Full Physical Exam _____
ϒ Bone Density _____
ϒ Colonoscopy _____
ϒ Cardiac Stress Test _____
ϒ EBT Heart Scan _____
ϒ EKG _____
ϒ Hemoccult Test-stool test for blood
_____
ϒ Mammogram _____
ϒ MRI _____
ϒ CT scan _____
ϒ Upper Endoscopy _____
ϒ Upper GI Series _____
ϒ Ultrasound _____

Surgeries
ϒ Appendectomy _____
ϒ Hysterectomy _____
ϒ Gall Bladder _____
ϒ Hernia _____
ϒ Tonsillectomy _____
ϒ Dental Surgery _____
ϒ Joint Replacement Knee/Hip
_____
ϒ Heart Surgery – Bypass Valve
_____
ϒ Angioplasty or Stent
_____

Family Medical History:

☐ Cancer ☐ Diabetes ☐ heart disease ☐ Stroke ☐ Depression

☐ Seizure ☐ Hepatitis ☐ Thyroid Disease ☐ Alcoholism ☐ High Blood Pressure

Other: _____

Nutrition and Health Goals:

- What are your main health and nutrition goals that you would like to achieve?
  _____
- Are there any specific changes you would like to make regarding your diet or lifestyle?
  _____
- Are there any habits or behaviors you would like to change when it comes to eating or living a healthier lifestyle? □ Yes □ No
- Do you have any weight-related or fitness goals that you would like to focus on through your nutrition? ☐ Yes ☐ No If yes than what_____

Preferences and Relationship with Food:

- How many ounces of water do you drink/day (1cup=8oz)?_____ Do you ever feel thirsty? _____
- What kind of water do you drink? tap___ bottled ___ filtered___ distilled ___
- What other beverages do you drink daily and how much? _____
- Do you eat three meals a day? ☐ Yes ☐ No If no, how many _____
- Are there any foods that you crave or binge on? ☐ Yes ☐ No If yes what foods? _____
  _____ _____ _____ _____
- Mealtimes: B_____ L_____ D_____ How many snacks /day? _____
- How many meals do you eat outside per week? ☐0-1 ☐1-3 ☐3-5 ☐ >5 meals per week
- What signals from your surroundings, or from your own mind make you want to eat, even when you are not hungry? ☐stress ☐ emotions ☐sight ☐ smell ☐ accessibility of food
- Do you have any positive or negative emotional experiences related to food? ☐ Yes ☐ No
- What is your experience with grocery shopping? _____
- What is your experience with meal planning? _____

- Are you comfortable with cooking or preparing meals at home? ☐ Yes ☐ No

- Are there certain foods or meals that you associate with comfort or emotions? ☐ Yes ☐ No
  How do they affect your eating choices? _____

- Do you tend to overeat? ☐ Yes☐ No

- What specific changes would you like to make in your relationship with food or your eating habits moving forward?
  _____

Dietary or Religious Restrictions

- Do you follow any specific dietary patterns or restrictions?
  ☐ Vegetarian ☐ Paleo ☐ Keto ☐ Low Fat ☐ High Protein ☐ Low Sodium ☐ Dairy-Free ☐ Gluten-Free

  ☐ Religious-Based (Kosher, Halal, etc.) ☐ Other: _____

- What foods do you commonly eat? _____

- Are there any foods you avoid due to personal beliefs or religious practices? ☐ Yes ☐ No If Yes, please explain: _____

- Have you ever been advised by a healthcare provider to avoid specific foods for medical reasons?
  ☐ Yes☐ No If Yes, please specify: _____

- Do you experience any physical symptoms after consuming certain foods (e.g., bloating, headaches, skin reactions)? ☐ Yes ☐ No If yes, which foods trigger symptoms?
  _____

- Are there any foods you strongly dislike or refuse to eat due to taste, texture, or past experiences?
  ☐ Yes☐ No If Yes, which foods? _____

- Do you have any cultural or traditional foods that are important to your diet?
  ☐ Yes ☐ No If Yes, please describe: _____

- Are there any beverages (caffeine, alcohol) you consume daily as part of your routine?
  ☐ Yes ☐ No If Yes, what are they? _____

201 King of Prussia Road, Suite 650, Radnor, PA 19087 | 610-679-4213 | humaira@holistichealthwellnesscenter.com

Additional Pertinent Information:

- Do you have mercury fillings? ☐ Yes ☐ No Radiation exposure: ☐ Yes ☐ No
- How often do you engage in physical activity (including cardio, strength training, flexibility, or sports? Daily ☐ A few times a week ☐ Occasionally ☐ Rarely/Never
- How motivated do you feel to exercise? ☐ Very motivated ☐ motivated ☐ Not motivated
- Do you sleep through the night? ☐ Yes ☐ No
- Does stress affect your ability to focus, work, or engage in daily activities? ☐ Yes ☐ No
- Do you feel supported by family, friends, or a community in your health and nutrition goals? ☐ Yes ☐ No
- What are your top goals for working with me?

Please bring the following to our first appointment:

1. Complete and bring 3 Days Food Diary form. (Download the 3_Days_Food_Diary form)
2. A copy of blood work done in the last 12 months or any other lab tests (ie hormonal, thyroid as well as CBC).

Plan of Action Notes (For Office Use)