



Holistic Life



# HOLISTIC HEALTH QUESTIONNAIRE

Please complete as much of this questionnaire as possible.  
Then, kindly **read and sign** the “understanding” on **page 3**.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Best way to contact? E-mail:  Phone:  Post Mail:

E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Daytime Evening

Birthdate: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Amount Over or Under Weight \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

What are your primary health concerns?

**Check known disease:**

- |  |   |                                  |                                    |
|--|---|----------------------------------|------------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Allergy | <input type="checkbox"/> Ulcers    |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Liver Diseases | <input type="checkbox"/> Asthma  | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Lung Problems  | <input type="checkbox"/> Others: |                                    |

\_\_\_\_\_  
\_\_\_\_\_

**About Yourself:**

Present Occupation: \_\_\_\_\_

Previous Occupations: \_\_\_\_\_

**Check one:** Single:  Married:  Widow(ed):  Divorced:  Separated:

**Live with:** Family:  Alone:  Other: \_\_\_\_\_

For Office Use Only  
Notes:

# Holistic Health Counseling

## CONFIDENTIAL QUESTIONNAIRE [P2]

### Personal Habits:

Do you smoke tobacco? Yes:  No:  If yes, how much? \_\_\_\_\_

If you've stopped, when did you quit? \_\_\_\_\_

Do you use recreational drugs? Yes:  No:  If so, which? \_\_\_\_\_

How often? \_\_\_\_\_ If you've stopped, when did you quit? \_\_\_\_\_

Do you currently take any pharmaceutical drugs or hormones? Yes:  No:

If yes, kindly list: \_\_\_\_\_

Do you drink coffee or sodas? Yes:  No:  If yes, how often? \_\_\_\_\_

Do you drink caffeinated teas? White:  Green:  Black:  If yes, how often? \_\_\_\_\_

### PERSONAL HEALTH HISTORY

Have you suffered from or do you currently suffer from any of the following conditions/ailments:

- |  |   |
|--|---|
| <p>Fevers, chills, night sweats..... Yes ___ No ___</p> <p>Frequent dizzy spells..... Yes ___ No ___</p> <p>Eye trouble..... Yes ___ No ___</p> <p>Trouble dealing with stress..... Yes ___ No ___</p> <p>Thyroid trouble..... Yes ___ No ___</p> <p>Mucus in chest of bronchial area..... Yes ___ No ___</p> <p>High blood pressure..... Yes ___ No ___</p> <p>Diarrhea..... Yes ___ No ___</p> <p>Alternating diarrhea &amp; constipation..... Yes ___ No ___</p> <p>Kidney or bladder stones..... Yes ___ No ___</p> <p>Diabetes or sugar in urine..... Yes ___ No ___</p> <p>Arthritis, Bursitis, Rheumatism..... Yes ___ No ___</p> <p>Pain in chest..... Yes ___ No ___</p> <p>Varicose veins..... Yes ___ No ___</p> <p>Black bowel movements..... Yes ___ No ___</p> <p>Do you sleep well?..... Yes ___ No ___</p> <p>Do you feel tired after eating?..... Yes ___ No ___</p> <p>Swollen lymph glands..... Yes ___ No ___</p> <p>Have you had your appendix removed? ... Yes ___ No ___</p> <p>Have you had your gallbladder removed? ___ Yes ___ No</p> | <p>Severe or frequent headaches..... Yes ___ No ___</p> <p>Hearing trouble..... Yes ___ No ___</p> <p>Do you feel anxious, depressed or irritable? .. Yes ___ No ___</p> <p>Frequent indigestion or gas..... Yes ___ No ___</p> <p>Asthma..... Yes ___ No ___</p> <p>Shortness of breath..... Yes ___ No ___</p> <p>Heart trouble..... Yes ___ No ___</p> <p>Constipation..... Yes ___ No ___</p> <p>Ulcer of stomach..... Yes ___ No ___</p> <p>Urinary infection..... Yes ___ No ___</p> <p>Hypoglycemia..... Yes ___ No ___</p> <p>Fast, irregular, or slow pulse..... Yes ___ No ___</p> <p>Allergies..... Yes ___ No ___</p> <p>Frequent colds or flu..... Yes ___ No ___</p> <p>Skin rashes..... Yes ___ No ___</p> <p>Do you feel rested in the morning?..... Yes ___ No ___</p> <p>Tired or diminished energy during the day? .. Yes ___ No ___</p> <p>Have you had your Tonsils removed? ..... Yes ___ No ___</p> <p>Do you eliminate at least once a day ..... Yes ___ No ___</p> |
|--|---|

Serious illnesses as an adult: \_\_\_\_\_

Have you ever been hospitalized and/or undergone an operation? Yes:  No:

If yes, please explain: \_\_\_\_\_

Date of last menstruation: \_\_\_\_\_ Are you pregnant? Yes:  No:

Has your weight changed in the past year? Yes:  No:  If yes, how much? \_\_\_\_\_

Current Weight: \_\_\_\_\_ Weight 1 year ago: (approx.) \_\_\_\_\_ Weight 5 years ago: (approx.) \_\_\_\_\_

# **Agreement & Understanding Prior To Wellness Consultation**

Prior to retaining the services, I certify that I clearly understand the following:

I, \_\_\_\_\_, the undersigned, do hereby acknowledge that I am aware that my holistic health counselor and educator is not a licensed (allopathic) medical doctor or licensed primary health care provider. I state that I come with the purity of purpose of seeking more information. I state that I do not come with any forethought or desire for entrapping Holistic Life, LLC or any of its practitioners into an illegal statement. If I am a member of the A.M.A., the F.D.A, or any law endorsement agency, or any city, county, state or federal regulatory agency, then I will identify myself as such before the appointment begins. I understand that my holistic health counselor's sole intention is offering to me general educational information I request. If I choose to use this information to work on myself then I affirm that the responsibility is mine. I understand that Holistic Life, LLC and its practitioner's feel one should never use information in any way that contradicts, conflicts, or opposes a course of treatment recommended by a primary health care provider such as a licensed medical doctor. If I ever perceive or feel that information given by my wellness professional opposes a licensed doctor's treatment or recommendations, I am strongly advised me to follow the advice and instruction of my licensed primary health care provider. I understand that Holistic Life, LLC and its staff, associates/practitioners are not providing medical services. I will not consider anything explained during our meetings to substitute in any way for consultation, diagnosis and treatment by a licensed primary health care provider, such as an M. D. Fatima Lowe-Williams and its staff are not licensed medical doctors (M. D.) or licensed primary health care providers. They do not diagnose, prescribe, or treat symptoms, defects, injury or disease. This appointment is for educational purposes only. If I want medical advice or treatment, I am encouraged to consult with a licensed primary health care provider. I consult with my practitioner in his/her capacity as a Wellness Profesional and Holistic Health Counselor who conveys self-help information that people can use to increase their own health and well-being. I affirm my 9th ammendment right to self treat, self health and I take full responsibility for my own wellness process.

I, the undersigned, do hereby voluntarily state to understand and acknowledge as accurate all the above comments.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_