DFW HOLISTIC HEALTH
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Name: ______________________________ Date: ________________

General Questions	Yes	No
Do you have any pets or farm animals? If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Both indoors and outdoors		
Have you lived or traveled outside of the United States? If so, when and where?		
Have you or your family recently experienced any life changes or major losses? If yes, please comment.		
What types of lawn service and pesticides are used around your home? ☐ Bug repellant ☐ Weed killer ☐ Fertilizer ☐ Other		

Unfortunately, abuse and violence of all kinds - verbal, emotional, physical, sexual - are leading contributors to chronic stress, illness, and immune system dysfunction and disease. Witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions.	Yes	No
Did you feel safe growing up?		
Have you been involved in an abusive relationship in your life?		
Was alcoholism or substance abuse present in your childhood home?		
Is alcoholism or substance abuse present now in your home or relationship?		
Do you currently feel safe in your home?		
Do you feel safe, respected, and valued in your current relationship?		
Have you had any violent or otherwise traumatic life experiences?		
Have you witnessed any violence or abuse?		

Name: ______________________________ Date: ________________

Past Medical and Surgical History

ILLNESSES / INJURIES	When	Comments
☐ Anemia		
☐ Arthritis		
☐ Asthma		
☐ Bronchitis		
☐ Cancer		
☐ Chronic Fatigue Syndrome		
☐ Crohn’s, Ulcerative Colitis, IBS		
☐ Diabetes		
☐ Emphysema		
☐ Epilepsy, convulsions, seizures		
☐ Gallstones		
☐ Gout		
☐ Heart attack / Angina		
☐ Hepatitis		
☐ High blood fats (cholesterol, triglycerides)		
☐ High blood pressure (hypertension)		
☐ Kidney stones		
☐ Mononucleosis		
☐ Pneumonia		
☐ Rheumatic fever		
☐ Sinusitis		
☐ Sleep apnea		
☐ Stroke		
☐ Thyroid disease, Hashimotos, etc.		
☐ Back, Neck, Spinal injury		
☐ Broken bone(s)		
☐ Head injury		

Name: ______________________________ Date: ______________

DIAGNOSTIC STUDIES	When	Comments
☐ Bone Scan		
☐ CAT Scan (location(s), MRI, US, etc.		
☐ Colonoscopy, Endoscopy		
☐ EKG		
☐ X-Ray (body location(s))		

OPERATIONS	When	Comments
☐ Appendectomy		
☐ Gallbladder		
☐ Hernia		
☐ Hysterectomy (Full, Partial)		
☐ Tonsillectomy / Adenoid		
☐ Other		
☐ Other		

PREGNANCY / MISCARRIAGE (Women)	
When	Comments

HOSPITALIZATIONS - Where	When	For What Reason

Do you have any artificial joints or implants?		
Where	What Kind	When Were They Put In

Name: ______________________ Date: ______________

VACCINATIONS (other than infant/childhood) Flu, HPV, Pneumonia, Shingles, Covid, etc.	When	Comments

How often have you taken antibiotics? How often have you been given steroids (oral, inhaler, corticosteroid injection)? (Not anabolic)				
	Antibiotic		Steroid (state which type)	
	More than 5 times	Less than 5 times	More than 5 times	Less than 5 times
Infant / Childhood				
Teen				
Adult				

What medications are you taking? Include non-prescription/OTC drugs.	Date Started	Dosage

Are you allergic to any medication? If yes, please list them.	

Have you ever taken a Sulfa-based antibiotic or drug?	Yes	No
Sulfamethoxazole-trimethoprim (Septra, Bactrim)		
Erythromycin-sulfisoxazole Sulfasalazine		
Azulfidine, used to treat Crohn’s disease, ulcerative colitis, and rheumatoid arthritis		
Dapsone, used to treat dermatitis and certain types of pneumonia		

Name: ______________________________ Date: ____________________

List all vitamins, minerals, and other nutritional supplements that you are taking. Indicate dosage in mg or IU, as well as form (e.g., calcium carbonate vs. calcium lactate), when possible.		
Brand Name	Date Started	Dosage (mg or IU)

ORAL HEALTH HISTORY	Date(s)	Comments
☐ Root canal(s)		
☐ Infected tooth / teeth / dry socket		
☐ Bridge(s)		
☐ Dentures		
☐ Implant(s)		
☐ Metal fillings(s)		
☐ Metal filling(s) removed		
☐ Wisdom teeth removed		
☐ Crown(s)		
☐ Last cleaning		
☐ Other		

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CHILDHOOD	Yes	No	Don't Know / Comments
Were you a full term baby?			
Were you breast-fed?			
Were you bottle-fed?			
As a child, did you eat a lot of sugar and candy?			

NICOTINE	Yes	No
Have you ever used tobacco?		
Do you still use tobacco?		

NICOTINE. If yes to either, what type of nicotine have you used, or do you currently use?			
	Amount per day	How many years	Year quit
☐ Cigarette			
☐ Cigar			
☐ Pipe			
☐ Smokeless / Chew			
☐ Patch / Gum			
☐ Vape			

NICOTINE	Yes	No
Are you currently being, or have you ever been, exposed to second-hand smoke regularly?		

ANY ADDITIONAL NOTES: