DFW HOLISTIC HEALTH

9149 Belshire Dr., Suite 100, North Richland Hills, TX 76182
817-801-5111 | Fax: 833-790-4178 | dfwholistichealth@gmail.com

Name: _____ Date_____

1. Do you have any pets or farm animals? Yes____No_____
   If yes, where do they live? 1._____indoors 2._____outdoors 3._____both indoors and outdoors

2. Have you lived or traveled outside of the United States? Yes____No_____
   If so, when and where? _____
   _____

3. Have you or your family recently experienced any major life changes? Yes____No_____
   If yes, please comment: _____
   _____

4. Have you experienced any major losses in life? Yes____No_____
   If so, please comment: _____
   _____

5. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; 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:
   a. Did you feel safe growing up?
      ☐ Yes ☐ No
   b. Have you been involved in abusive relationships in your life?
      ☐ Yes ☐ No
   c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
      ☐ Yes ☐ No
   d. Do you currently feel safe in your home?
      ☐ Yes ☐ No
   e. Do you feel safe, respected and valued in your current relationship?
      ☐ Yes ☐ No
   f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
      ☐ Yes ☐ No

6. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		

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	ILLNESSES	WHEN	COMMENTS
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
ab.	Back injury		
ac.	Broken Bone		
ad.	Head injury		
ae.	Neck/Spinal injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan (note location(s))		
aj.	Chest X-ray		
ak.	Colonoscopy		
al.	EKG		
am.	Liver scan		
an.	X-ray (note location(s))		
ao.	NMR/MRI		

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ap.	Upper GI Series		
aq.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
ar.	Appendectomy		
as.	Dental Surgery		
at.	Gall Bladder		
au.	Hernia		
av.	Hysterectomy		
aw.	Tonsillectomy		
ax.	Other (describe)		
ay.	Other (describe)		

7. Hospitalizations:

WHERE HOSPITALIZED	**WHEN**	**FOR WHAT REASON**
a.		
b.		
c.		
d.		
e.		

8. How often have you have taken antibiotics?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

9. How often have you have been given oral steroids, steroid inhaler or corticosteroid injection (e.g., Cortisone, Prednisone, etc.)? (Not anabolic steroids)

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

10. What medications are you taking now? Include non-prescription drugs.

Medication Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		

Are you allergic to any medications?
If yes, please list:

_____
_____
_____
_____

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Have you ever taken a Sulfa based antibiotic or drug?

Sulfamethoxazole-trimethoprim (Septra, Bactrim) ☐ Yes ☐ No

Erythromycin-sulfisoxazoleSulfasalazine ☐ Yes ☐ No

Azulfidine used to treat Crohn's disease, ulcerative colitis and rheumatoid arthritis ☐ Yes ☐ No

Dapsone used to treat dermatitis and certain types of pneumonia ☐ Yes ☐ No

11. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name INCLUDE BRAND	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		

12. Childhood:

Question	**Yes**	**No**	**Don't Know**	**Comment**
1. Were you a full term baby?				
a. Breast fed?				
b. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

13. Have you ever used tobacco? Yes____No_____
If yes, number of years as a nicotine user_____. Amount per day_____. Year quit_____.
If yes, what type of nicotine have you used?_____Cigarette _____Smokeless _____Chew
_____Cigar _____Pipe _____Patch/Gum

14. Are you currently or ever been exposed to second hand smoke regularly? Yes____No_____

15. Do you currently have mercury amalgam/metal fillings? Yes____No_____

Have you had mercury amalgam/metal fillings removed? Yes____ No____ When _____

16. Do you have any artificial joints and/or implants, anywhere in the body? Yes____No_____

If yes, where and what kind, and when put in _____