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HERBALIST & HOLISTIC HEALTH EDUCATOR

HEALTH EVALUTATION

GENERAL INFORMATION: *(All information is kept strictly confidential)*

Date _____
Name: _____ Gender: Male Female
Birth Date: _____ Age: _____ Place of Birth: _____
Address _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Email: _____ Occupation: _____
How did you hear about my services? _____

PART I: HEALTH PROFILE

HISTORY

Height: _____ Weight: _____ Desired Weight: _____ Has your weight changed recently? _____
Primary Care Physician: _____
Date of last complete physical: _____ Blood Type: _____
Are you currently receiving care from other health professionals? Please provide names/services.

How would you describe your health up to this time? _____

When you do get sick, how often does it happen and what is your recovery time? _____

Did you miss much school as a child? Do you miss much work? If yes, for what reasons. _____

What major injuries or accidents have you had?
Injury When Long-term effects

What hospitalizations or surgeries have you had? (appendix, tonsils, wisdom teeth, implants, etc.)
Surgery/Hospital When Complications

Are there any of the above conditions after which you have never been totally well again, or which have been more severe than usual? _____

How have you dealt with your health issues? (Doctor, medication, alternative care, etc.) _____

Reason for Visit: _____

What do you hope to achieve by working together? _____

What are your primary health concerns/complaint and the order of importance for you?

List Complaint(s)/Symptom	Since	Cause
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What previous medical diagnosis by an MD, ND, Chiropractor, Acupuncturist or anyone else have you had? Do you have any lab results? _____

Was there anything different about your life at the time of the onset? _____

How did you address these concerns before now? _____

Do you feel better or worse at any particular time of the day? _____

Do any family members have similar health concerns now or in the past? _____

Do any medical conditions run in the family? _____

Please list all medications you are currently taking (including aspirin, antacids, laxatives, sleep aids, etc.) and indicate if they are over the counter (OTC) or Prescribed (P).

Product	OTC or P	Dosage	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all vitamin, mineral, herbal or other supplements you take regularly.

Product	How long?	Reason for taking	Overseeing usage?	Results
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Living Situation: Alone Friends Partner Spouse Parents Children Pets
Names and ages of those living with you: _____

How much time do you devote to rest, self care, personal time, recreation, creativity? _____

What do you do to relax? _____

Are you happy in your life right now? _____

Do you have quality time with family and friends? _____

Do you have enough support? _____

What types of physical activities or exercise do you do? How often? _____

How much sleep do you usually get on an average night? Describe quality. _____

How is your energy level: poor, fair, good? _____

Does your energy level fluctuate during the day? _____

How many hours do you work at you job per week? _____

Do you like your current job? _____

Is there much stress in your life? _____

What causes the most stress for you? _____

How do you handle stress? _____

When you are under stress, what part of your body do you feel it? _____

What emotion do you most often experience?

Joy Happiness Anger Sadness Depression Fear Anxiety Sympathy Worry

Do you work in or have you worked in an environment where you are exposed to pesticides, chemicals, heavy metals, or other toxins? _____

Do you spray your house for pests or yard for weeds? ____ Use cosmetics/hair treatments? ____

How much of the following substances are you using and how often?

Tobacco: _____ Coffee: _____ Tea: _____

Alcohol: _____ Recreational Drugs: _____

What are your obstacles to living a healthy lifestyle? _____

What is your current eating pattern? _____

Do you enjoy the food you eat? _____

Do you have regular meal times? _____

Do you eat slowly and chew your food? _____

Has your diet changed in regards to your current health concerns? _____

- If yes, how so? _____

- If yes, what was your diet like at the time your health concerns started? _____

Have you experienced periods of eating junk foods, restrictive dieting or binge eating? _____

Please explain: When? How long? _____

How many times do you eat out per week? _____

How many times do you eat “fast foods” per week? _____

Do you reach for certain foods to cope with stress or emotions? Which ones? _____

What are your comfort foods? _____

Do you use artificial sweeteners? Which ones? How often? _____

What is your relationship with sugar? Frequency and amount? _____

Please describe your typical diet and eating patterns while growing up. _____

Please describe a current typical day’s diet.

Are you on a special diet? Explain. _____

How many glasses (8 oz.) of water do you typically drink per day? _____

Do you drink soda? Yes No Type: _____ How much per day? _____

Describe your appetite in the morning, afternoon, and evening. _____

How do you feel if you skip a meal or eat sugary foods? _____

Do you have food sensitivities, allergies or restrictions? If so, what is your reaction? _____

Is there any reason you cannot ingest herbal remedies prepared in food grade alcohol? _____

Do you crave any of the following foods: sweets, chocolate, breads, fatty foods, salty foods, dairy, meat, others? _____

After eating, do you feel well nourished and energized or tired and sluggish? _____

What foods are available and accessible for you? _____

Where do you shop for food? _____

How often do you prepare your own meals? _____

What are your challenges or barriers to eating healthy? _____

DIETARY OVERVIEW Please indicate your:

	Most Nutritious	Usual	Least Nutritious
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Snack	_____	_____	_____
Dinner	_____	_____	_____
Beverages	_____	_____	_____

Please also fill out 3-day Food, Liquid & Activity form if asked to do so.

In general, I feel my health is:

___ Excellent ___ Good ___ Fair ___ Poor

Describe what being healthy means to you. _____

Can you imagine being completely healthy? _____

How would your life be different if health was not an issue? _____

Would you be willing to make changes in your current diet or lifestyle if you believed it would be beneficial to your health? _____

Do you have friends or family who will be supportive of you during your healing process? _____

What is your desired health outcome? _____

Is there anything else you would like to share?
