Valdeniece Holistic Wellness Ministries
New Client Questionnaire

Please allow 30-45 minutes to complete this questionnaire as thoroughly as possible to assist me in making the best possible clinical assessment. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you. That said, please answer only questions you are comfortable answering.

Name_____Today' Date _____
Address_____
Telephone _____ Email:_____ Best way to contact you:_____
Emergency Contact Name: _____ Relationship:_____ Phone:_____
Date of Birth _____ Age_____ Gender: _____ Height & Weight _____

What are your primary goals in working with an herbalist?
1._____
2._____
3._____

What other health-related issues do you have/have you had in the past?
_____
_____
_____

Please list any other practitioners you are currently working with (type of practitioner and name)
_____
_____
_____

In order to support your health, are you willing to make modifications to your
Diet _____ and lifestyle _____ ?

Medications currently or previously used (over the counter and prescription):
Please feel free to attach a separate list or continue on the back if you are taking more medications or supplements than the space available permits you to list.

Medications	*Dosage/Frequency/Taking How Long?*	*For What Reason Are You Taking It*

Supplements/Vitamins/Herbs Currently Used

Supplements (Include Brand)	*Dosage/Frequency/Taking How Long?*	*For What Reason Are You Taking It*

Family Health History

Relationship Alive/Deceased Present health or cause of death

Father_____

Mother_____

Brothers_____

Sisters_____

Children/ages_____

_____

_____

_____

Have you or any blood relatives had any of the following? *star next to those that apply to you

Allergies/Asthma	Arthritis	Bleeding/Clotting Disorder
Cancer-Type:	Diabetes	Headaches/Migraines
Heart Disease	High Blood Pressure	Kidney Disease
Liver Disease	Obesity	Stroke
Addiction	Thyroid Disease	Tuberculosis
Depression	Gallstones	Other_____

General Health Questions:

Education: _____ Passions/Interests: _____

Occupation _____ How long? _____ Previous occupations: _____

_____

Where and when have you lived or traveled outside the U.S. and Canada?_____

_____

_____

Describe living situation _____

Do you believe in a spiritual path / higher power_____

Do you spend time alone? _____ Do thing for yourself? _____ Have regular group activities? _____

Are you allergic or sensitive to any substance (medications, pollens)? _____

Have you had any surgeries? _____ For what reason(s)? _____

Describe any complications: _____

Have you had lengthy exposure to environmental toxins (work w/chemicals? home near polluted area)? _____ _____

Do you have mercury or amalgam fillings? _____

Highest weight as an adult: _____ Year: _____ Lowest weight as an adult: _____ Year: _____

Typical hours spent watching TV per day _____ Typical hours on the computer per day ____

Exercise - type/frequency/for how long_____

Typical bedtime _____ Typical hours asleep _____ Do you feel rested upon waking? _____

Relationship Status: _____ Partner's Gender: _____
Are you satisfied with your primary relationships and/or your support system?
_____
Are you currently sexually active? _____
If applicable, are you using any safer sex methods (i.e. condoms /dams) or birth control methods (i.e. IUD, patch/ ring, fertility awareness) and for how long? _____
Are you now pregnant? _____ Are you currently breastfeeding? _____
Are you or your partner actively trying to conceive? _____ For how long? _____

*** If you discover that you are pregnant during the course of our work together, please discontinue all herbal supplements until we can discuss whether your recommendations need to be modified ***
On a scale from 1 (low) to 10 (high), how stressful is your: Work? __ Health status? __ Social/family situation? ___ Are you satisfied with your energy levels? Yes Sometimes No
What would you describe as the dominant emotions in your life right now? (joy, worry, satisfaction, anger, fear, inspiration, etc.)

Diet:
Please check boxes and indicate how often you consume the following (daily, weekly, monthly, etc)

___Dairy Products	___Beans	___Eggs
___Soft Drinks	___Soy Products	___Alcohol
___Margarine	___Fish	___Fried Foods
___Butter	___Chicken, Turkey	___Tobacco
___Nuts & Seeds	___Vegetables	___Coffee
___Fruits	___Red Meat	___Baked Goods
___Greens (Kale, Collards, Etc.)	___Water	___Chips/Crackers/Pretzels

Please estimate the percentage of food you buy from the supermarket_____ ; Co-op / farmers market_____
How often do you eat at restaurants? _____ How often do you cook/prepare food? _____
How many meals do you eat a day? _____
How often do you snack and when?_____
What foods do you crave? _____
Do you follow or have you ever followed a restricted diet? Which one(s)? _____
_____
List any food(s) that your are allergic or sensitive to _____

Please indicate an example of (1) your diet when you have time and energy to prepare meals and (2) a typical diet when stressed or pressed for time. Please include beverages.

(1): Breakfast	**Lunch**	**Dinner**	**Snack**
(2): Breakfast	**Lunch**	**Dinner**	**Dinner**

Please check anything you have experienced in the past year. Any issues that you had previously, but no longer have, mark with a "P"

___ Abnormal Pap	___ Frequent Cold Sores	___ Nausea	___ Sinus Infection
___ Bruise Easily	___ Frequent Diarrhea	___ Night Sweats	___ Shingles
___ Breast Lumps/Fibroids	___ Frequent Gas	___ Nose Bleeds	___ Skin Rashes
___ Chemically Sensitive	___ Gum Problems	___ Numbness	___ Swollen Glands
___ Chest Pains	___ Hearing Problems	___ Ovarian Cysts/PCOS	___ Tinnitus (Ringing in Ears)
___ Chronic Fatigue	___ Heart Palpitations	___ Painful Intercourse	___ Ulsers
___ Depression	___ Heartburn/GERD	___ Phobias	___ Urinary Tract Infections
___ Digestive Issues	___ Hysterectomy	___ Prostate Pain	___ Uterine Fabriods
___ EarAches	___ Incontinence	___ Poor Consentration	___ Vaginal Dryness
___ Eczema	___ Low Libido	___ Respiratory Issues	___ Vasectomy
___ Endometriosis	___ Lime Disease	___ Sexually Transmitted Infection	
___ Fainting	___ Memory Loss	___ Seizures	

In each row, please read across the three columns and circle the box(es) that best describe you. You may circle more than one box per row.

General	Variable Energy	Consistent High Energy	Slow to start, but Steady Energy
	Tendency Toward being cold	Tendency Toward being warm	
	Love to travel	Action Oriented	Love to stay at home
	Lose weight easily	Maintain Weight Easily	Gain weight easily
	Variable Sleep	Deep, but short sleep	Deep Sleep
	Wake easily	Generally Awake Refreshed	Generally waking is difficult
	Love Privacy	Love Risk & Adventure	Love Affection & Approval

Mind	Live in future	Live in present	Live in past
	Creative, Visionary	Bold, Courageous	Calm, Resilient
When Stressed, Tendency Towards	Fear / Anxiety	Quick to anger	Despondency
	Difficulty Focusing	Focused mind	
Hyperventilate/forget to breathe when stressed	Emotions Difficult to Control	Controlled Emotions	Not much variance in emotions
	Need Solitude when stressed	Need action when stressed	Need people when stressed
Memory	Good short-term; Poor long-term	Detailed oriented	Good long-term, poor short-term
Renal /Bladder	Frequent dizziness on standing/ low blood pressure		
	Frequent Thirsty (Fluids “run right though”)	Hot weather aggravates urinary symptoms	Infrequent thirst
	Urgent need to urinate when nervous	Infrequent Urination In hot weather	
	Urine almost always clear	Urine usually yellow	Urine often cloudy
	Frequent Urination		Urination infrequently; large volume
	Prefer Moist Environments		Prefer dry environment
	Crave Salt		Feels worse when using salt
Respiratory	Respiratory Tract Easily irritated by smoke/ irritants	Respiratory symptoms worst in hot air / environments	Respiratory tract feels better with spicy foods
	Respiratory tract easily irritated by dry air	Respiratory Tract feels inflamed (“Hot, burning, irritated”)	Respiratory Symptoms worse in cool/damp air
	Nasal Passage Often Dry		Nasal passage or sinuses feel full or swollen
	Shallow Breather		Infection tends to settle in lungs
		Frequent yellow Or green mucus	Frequent clear/white mucus

Menses	Menses Irregular	Menses predictable	
	Sharp, Stabbing Cramps		Pressing, dull, aching cramps
		Loose stools with menses	Constipation before menses
	Fatigue with menses		Water retention before menses
	Menses start with red blood		Menses starts with brown blood/ spotting
Skin/Hair	Skin is cool & dry	Skin is warm & moist	Skin is cool & moist
	Skin is thin & flaky	Skin is firm	Skin is soft & smooth
	Dry hair and scalp	Thin hair, tends toward oily, may have receding hair line	Thick, shiny hair
	Lips chap easily		
	Nails brittle/cracked	Soft, flexible nails	Strong thick nails
	Skin is worse in winter	Skin is worse in summer	Skin is worse in damp
		Skin is red & easily inflamed	
Digestion	Variable Appetite	Strong demanding hunger	Predictable appetite
	Dry, pebbly stools	Loose and regular stools	Sluggish or regular bowels
	Alternating constipation / Diarrhea	Burning sensation after eating	Feel heavy/ stuck after eating
	Frequent Gas, Pain	Yellowish/ Light brown stools	Foul-smelling gas
	Often forget to eat	Think of food as fuel to keep going	Eat to calm down
	Difficulty digesting heavy foods	Strong digestion	
	Need to eat frequently		Feel good on only 1 to 2 meals a day
	Quick defecation after eating		
Cardiovascular	Rapid, erratic pulse	Strong Pulse	Slow pulse, Steady

	Cold hands & feet	Feels warm/ hot most of the time	Tendency towards Edema, Swelling
	Difficulty adjusting to temperature		
	Heart palpitations when stressed		
	Frequent low blood pressure	Tendency to high blood pressure	
Immunity	Complete exhaustion when ill	Attempt to work through illness	Take time off for slight hint of illness
	Recuperating from illness variable	Recuperate Quickly After illness	Recuperate slowly after illness
	Inflammation comes & goes	Easily inflamed, resolves quickly	Inflammation resolves Slowly
	Arthritis / Rheumatism worse with cold	Arthritis worse with heat	Arthritis/rheumatism worse with cold/damp

Please list major events in the last ten years of your life (or further back if it seems significant) and the dates they occurred. Include events such as births, deaths, marriages, divorces, accidents, moves, jobs changes, miscarriages, illnesses and anything else you feel greatly impacted your life.

Date Event