Wholistic Wellness

Self-Assessment Health Questionnaire

First Name: Last Name:

Gender: ☐ Male / ☐ Female Age: Height: (ft) (in) Weight: (lbs)

Email Address: Skype Name:

Home Address: City: State:

Zip Code: Country: Province:

Home Phone # ( ) Cell Phone # ( )

Your Counselor may recommend *certain formulas to tackle* certain areas. Please select your preference for a Councelor recommendation: (Check One) ☐ **Preferred** ☐ **Not Preferred**

(Check One) ☐ I currently use Wholistic Formulas /
I have used Wholistic Formulas in the past ☐ / ☐ I have never used Wholistic Formulas before

Vitals:

If you are unsure of any of these readings, you may leave them blank.

Blood Pressure: **Right:** **Left:** Eye Color: (Circle One) Brown ☐ Blue ☐

Resting Pulse: (bpm) Basal Temp. (F) Urine pH: Saliva pH:

How Many Bowel Movements do You Have Daily?

Are you taking any medications? Please list individually below:

1. 5.
2. 6.
3. 7.
4. 8.

Are you taking any Herbal Products or Supplements? Please list individually below:

1. 5.
2. 6.
3. 7.
4. 8.

What does your current daily diet consist of?

Please be as honest as possible.

Breakfast:

Lunch:

Dinner:

Snack:

What are your primary health concerns?

What do you hope to gain from this program?

Genetic / Family History

Please list all known health concerns for each family member. Leave blank if you aren't sure.

Mother:

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Sister/Brother:

Sister/Brother:

Sister/Brother:

Sister/Brother:

Previous Surgical Procedures

Please list all surgical procedures, minor or major, along with the year

Year:

Year:

Year:

Year:

Year:

Do you, or have you ever had difficulty with any of the following?

Please circle all applicable, and indicate: Current, Past, or N/A

Thyroid/ Glandular System	Cold Hands or Feet	Current	◯	Past	◯	N/A ◯
	Frequently Cold / Difficulty Warming	Current	◯	Past	◯	N/A ◯
	Cold, but Burning Inside?	Current	◯	Past	◯	N/A ◯
	Easy to Gain Weight and Hard to Lose It	Current	◯	Past	◯	N/A ◯
	Irregular Heart Beat / Arrythmia's (Also Adrenals/Cardiovascular)	Current	◯	Past	◯	N/A ◯
	Headaches / Migraines	Current	◯	Past	◯	N/A ◯
	Easily Irritable	Current	◯	Past	◯	N/A ◯
	Overweight	Current	◯	Past	◯	N/A ◯
	Low Energy / Always Tired	Current	◯	Past	◯	N/A ◯
	Goiter ◯/ Hashimoto's ◯/ Grave's ◯/ Reidel's Disease ◯	Current	◯	Past	◯	N/A ◯
	Family Member with ◯Goiter / ◯Hashimoto's / Grave's ◯ /Reidel's Disease ◯	Current	◯	Past	◯	N/A ◯
	How Much do You Sweat?	Low	◯	Medium	◯	Excessive ◯
Parathyroid	Are Your Fingernails: (Check all Applicable)	Ridged	◯	Brittle	◯	Weak ◯
	◯ Varicose Veins / ◯Spider Veins	Current	◯	Past	◯	N/A ◯
	◯Hemorrhoids / ◯Prolapses	Current	◯	Past	◯	N/A ◯
	Muscle Cramps / Legs Tire Easily	Current	◯	Past	◯	N/A ◯
	Is Your Bladder:	Strong ◯		A Few Leaks ◯		Weak ◯
	Hernia	Current	◯	Past	◯	N/A ◯
	Aneurysm	Current	◯	Past	◯	N/A ◯
	◯ Low Bone Density / ◯Low Calcium	Current	◯	Past	◯	N/A ◯
	◯Osteoporosis /◯Scoliosis / ◯Kyphosis / Lordosis ◯	Current	◯	Past	◯	N/A ◯
	Mental Health Challenges (Depression, PTSD, OCD, etc.) Please List:	Current	◯	Past	◯	N/A ◯
	◯Spinal Deterioration / ◯Herniated Discs / Bone Spurs ◯	Current	◯	Past	◯	N/A ◯
	Bruise Easy	Current	◯	Past	◯	N/A ◯

Pancreas	Slow Digestion	Current ○	Past ○	N/A ○
	Food Passes Quickly Through You (Diarrhea)	Current ○	Past ○	N/A ○
	☐ Acid Reflux / ☐ Heartburn / ☐ Indigestion	Current ○	Past ○	N/A ○
	Undigested Food in Stool	Current ○	Past ○	N/A ○
	Thin / Difficulty Gaining Weight	Current ○	Past ○	N/A ○
	Moles (Also Adrenals)	Current ○	Past ○	N/A ○
Adrenals (Glandular System)	Overweight	Current ○	Past ○	N/A ○
	☐ MS / ☐ ALS / ☐ Parkinson's / ☐ Palsy	Current ○	Past ○	N/A ○
	Anxiety	Current ○	Past ○	N/A ○
	Excessive Shyness / Inferiority Complex	Current ○	Past ○	N/A ○
	Tremors / Nervous Legs	Current ○	Past ○	N/A ○
	High Blood Pressure (Also Cardiovascular)	Current ○	Past ○	N/A ○
	Low Blood Pressure	Current ○	Past ○	N/A ○
	Hypoglycemia (Low Blood Sugar)	Current ○	Past ○	N/A ○
	Diabetes: ☐ **TYPE I** / ☐ **TYPE 2**	Current ○	Past ○	N/A ○
	Tinnitus (Ringing in Ears)	Current ○	Past ○	N/A ○
	☐ Difficulty Taking Deep Breath / ☐ S.O.B (Short of Breath)	Current ○	Past ○	N/A ○
	Cardiac Arrythmia : (Also Cardiovascular) Please List Which Type:	Current ○	Past ○	N/A ○
	Sleep Challenges: Difficulty Getting to Sleep (Also Pineal)	Current ○	Past ○	N/A ○
	Sleep Challenges: Difficulty Staying Asleep (Also Pituitary)	Current ○	Past ○	N/A ○
	CFS (Chronic Fatigue Syndrome)	Current ○	Past ○	N/A ○
	☐ Addison's Disease / ☐ Congenital Adrenal Hyperplasia	Current ○	Past ○	N/A ○
	High Cholesterol	Current ○	Past ○	N/A ○
	Do You Have *any* "Itis" Condition (Arthritis, Osteoarthritis, Bursitis, etc) Please List:	Current ○	Past ○	N/A ○
	Low Steroids / Low Cortisol	Current ○	Past ○	N/A ○
	☐ ADD / ☐ ADHD / ☐ Autism	Current ○	Past ○	N/A ○

Females Only	Are You Currently Pregnant?	Yes	◯			No	◯
	Are You Currently Breastfeeding?	Yes	◯			No	◯
	Irregular Menses (Also Pituitary)	Current	◯	Past	◯	N/A	◯
	Excessive Bleeding During Menstruation	Current	◯	Past	◯	N/A	◯
	☐ Ovarian Cysts / ☐ Fibroids	Current	◯	Past	◯	N/A	◯
	☐ Endometriosis / ☐ Atypical Cells	Current	◯	Past	◯	N/A	◯
	Fibrocystic Breasts	Current	◯	Past	◯	N/A	◯
	Sore or Painful Breasts, Especially During Menstruation	Current	◯	Past	◯	N/A	◯
	☐ Low / ☐ Excessive Sex Drive	Current	◯	Past	◯	N/A	◯
	Have You Had a: ☐ Complete Hysterectomy / Partial Hysterectomy ☐	Current	◯	Past	◯	N/A	◯
	If Yes, Were Any Other Organs / Lymph Nodes Removed? Please List Which:						
	Difficulty Conceiving	Current	◯	Past	◯	N/A	◯
	Birth Control Pills? For How Long:	Current	◯	Past	◯	N/A	◯
Males Only	Do You Have Prostatitis? How Often do You Urinate?	Current	◯	Past	◯	N/A	◯
	Have You Been Diagnosed With Prostate 'Cancer'?	Current	◯	Past	◯	N/A	◯
	What are Your PSA's?	Current	◯	Past	◯	N/A	◯
	Testicular Hypertrophy (Enlarged Testicles)	Current	◯	Past	◯	N/A	◯
	☐ Low / ☐ Excessive Sex Drive	Current	◯	Past	◯	N/A	◯
	Erection Problems	Current	◯	Past	◯	N/A	◯
	Premature Ejaculation	Current	◯	Past	◯	N/A	◯
Gastro-Intestinal Tract	Bowel Movements per Day:	0 - 1	◯	2	◯	3 ◯	4+ ◯
	☐ Crohn's / ☐ Colitis / ☐ Gastritis / ☐ Enteritis / Diverticulitis ☐	Current	◯	Past	◯	N/A	◯
	Gastroparesis (Paralysis of the Stomach)	Current	◯	Past	◯	N/A	◯
	Hiatus Hernia	Current	◯	Past	◯	N/A	◯
	Coated Tongue, Especially Upon Waking: (white, yellow, green, brown)	Current	◯	Past	◯	N/A	◯
	☐ Diarrhea / ☐ Constipation	Current	◯	Past	◯	N/A	◯
	☐ Stomach / ☐ Intestinal Ulcers	Current	◯	Past	◯	N/A	◯
	Gastro-Intestinal 'Cancer': Please Provide Location of 'Cancer':	Current	◯	Past	◯	N/A	◯
	Gas Problems (Also Pancreas)	Current	◯	Past	◯	N/A	◯
	Other GI Issues Not Listed:	Current	◯	Past	◯	N/A	◯

Liver / Gallbladder / Blood	Difficulty Digesting Fats	Current ○	Past ○	N/A ○			
	Fats or Dairy Cause Stomach: ☐ Bloat / ☐ Pain	Current ○	Past ○	N/A ○			
	Light Colored or White Stools	Current ○	Past ○	N/A ○			
	Pain Mid-Back (Especially After Eating)	Current ○	Past ○	N/A ○			
	'Liver' or Brown Spots (Not Freckles)	Current ○	Past ○	N/A ○			
	Skin Pigmentation Irregularities or Changes (Also Pituitary)	Current ○	Past ○	N/A ○			
	Jaundice of: ☐ Eyes / ☐ Skin	Current ○	Past ○	N/A ○			
	Anemia	Current ○	Past ○	N/A ○			
	Hepatitis ☐ A, ☐ B, or ☐ C	Current ○	Past ○	N/A ○			
	Alcohol Consumption:	Don't Drink ○	Daily ○	Weekly ○	Monthly or Less ○		
Cardiovascular	Angina / Chest Pain	Current ○	Past ○	N/A ○			
	Myocardial Infarction (Heart Attack)	Current ○	Past ○	N/A ○			
	☐ Pacemaker / ☐ Stents / ☐ Other Open Heart Surgery	Current ○	Past ○	N/A ○			
	Do You Feel Pressure on Your Chest?	Current ○	Past ○	N/A ○			
	Do You Feel 'Prickly' Pains? Please List Where:	Current ○	Past ○	N/A ○			
Skin	☐ Blemishes / ☐ Rashes / ☐ Acne	Current ○	Past ○	N/A ○			
	☐ Dermatitis / ☐ Eczema / ☐ Psoriasis	Current ○	Past ○	N/A ○			
	Dry, Itchy Skin	Current ○	Past ○	N/A ○			
	Excessively Oily Skin	Current ○	Past ○	N/A ○			
	Dandruff	Current ○	Past ○	N/A ○			
	Any Other Skin Problems: Please List:	Current ○	Past ○	N/A ○			
	Do You Have Any Tattoos?	Yes ☐		No ☐			

Lymphatic System

☐ Hair Loss / ☐ Balding / ☐ Fully Bald (not by choice)	Current	○	Past	○	N/A	○
Have You Ever Had Any Lymph Nodes Removed?	Yes	○			No	○
From Which Area of Your Body Were They Removed?					N/A	○
How Many Were Removed?					N/A	○
☐ Swollen Lymph Nodes / ☐ Lymphedema	Current	○	Past	○	N/A	○
Do You Have Edema (Fluid Retention)? Please Provide Location(s):	Current	○	Past	○	N/A	○
☐ Fibromyalgia / ☐ Scleroderma	Current	○	Past	○	N/A	○
Cold & Flu-like Symptoms	Current	○	Past	○	N/A	○
☐ Sore Throat / ☐ Sinus Problems	Current	○	Past	○	N/A	○
Poor Memory / Brain Fog	Current	○	Past	○	N/A	○
Blurred Vision	Current	○	Past	○	N/A	○
Mucus in Eyes Upon Waking	Current	○	Past	○	N/A	○
Have You Been Diagnosed With 'Cancer' ? Please Provide Location:	Current	○	Past	○	N/A	○
Other Type of Non-Malignant Mass / Tumor:	Fatty	○	Benign	○	N/A	○
Location of Non-Malignant Mass / Tumor:					N/A	○
☐ AIDS / ☐ HIV +	Current	○	Past	○	N/A	○
Low Platelet Count (Also Cardiovascular)	Current	○	Past	○	N/A	○
☐ Appendicitis / ☐ Appendectomy	Current	○	Past	○	N/A	○
Date of Appendicitis / Appendectomy:					N/A	○
Date of Tonsillectomy (Tonsils Removed):					N/A	○
☐ Boils / ☐ Pimples / ☐ Cysts / ☐ Abscesses	Current	○	Past	○	N/A	○
Gout	Current	○	Past	○	N/A	○
☐ Toxemia / ☐ Cellulitis	Current	○	Past	○	N/A	○
Sleep Apnea	Current	○	Past	○	N/A	○
Do You Snore?	Current	○	Past	○	N/A	○

Kidneys & Bladder	☐ UTI / ☐ Bladder Infection / ☐ Cystitis	Current ○	Past ○	N/A ○		
	Burning While Urinating	Current ○	Past ○	N/A ○		
	☐ Weak Bladder / ☐ Urinary Incontinence	Current ○	Past ○	N/A ○		
	Restricted Urine Flow	Current ○	Past ○	N/A ○		
	Kidney Stones	Current ○	Past ○	N/A ○		
	Nephritis	Current ○	Past ○	N/A ○		
	Cramping or Pain Mid-to Lower Back on Either Side	Current ○	Past ○	N/A ○		
	Lower Back Weakness / Lack of Strength	Current ○	Past ○	N/A ○		
	Sciatica	Current ○	Past ○	N/A ○		
	Bags Under Eyes	Current ○	Past ○	N/A ○		
Respiratory System	☐ Bronchitis / ☐ Asthma / ☐ COPD / Emphysema ☐ / Pneumonia ☐	Current ○	Past ○	N/A ○		
	Pain / Difficulty Breathing	Current ○	Past ○	N/A ○		
	Pain / Difficulty Taking Deep Breaths (Also Adrenals)	Current ○	Past ○	N/A ○		
	Collapsed Lung: ☐ Right or ☐ Left	Current ○	Past ○	N/A ○		
	Frequent Cough	Current ○	Past ○	N/A ○		
	Color of Mucus Expectorated: ○ Clear / ○ Yellow / Green ○ / Brown ○ / Black ○	Current ○	Past ○	N/A ○		
	Do You Use a : ☐ Nebulizer / ☐ Inhaler	Current ○	Past ○	N/A ○		
	What is Your Oxygen Saturation (or SP02)?			Don't Know ○		
	Have You Been Diagnosed With Lung 'Cancer'?	Current ○	Past ○	N/A ○		
	Are You a Smoker?	Current ○	Past ○	Never Smoked ○		
	How Much do You Smoke?	Packs/Day:	or	Cigarettes/ Day:		
Environmental and Other Toxic Exposure	Exposure to: ○ Nuclear Wastes / ○ By-Products of Nuclear Wastes / ○ Heavy Metals / ○ Toxic Chemicals	Current ○	Past ○	N/A ○		
	Exposure to Toxic Substances Such as Asbestos or Coal Mines (Also Respiratory System)	Current ○	Past ○	N/A ○		
	Have You Gone Through Chemotherapy or Radiation?	Current ○	Past ○	N/A ○		
	How Many Treatments of Chemo or Radiation?					
	Have You Received the "Standard" Vaccinations?	Yes ○		No ○		
	Have You Received Vaccinations for Travelling to Foreign Countries? (like Covid for example)	Yes ○		No ○		
	Have You Received a Flu Shot?	Yes ○		No ○		
	Have You Ever Used 'Recreational' Drugs? (this information is confidential and used to help you attain optimal health only!)	Current ○	Past ○	N/A ○		
	Please List Any 'Recreational' Drugs You Have Used:					