Confidential Health Assessment Solara Attatharya, DOM, AP, Dipl Homeopathy

The questions will help guide me to finding the solution in restoring your health. There are no fluff questions but Don't worry if there are some questions to which you don't have answers - just fill out what you can. We will go over the info during your appointment.

PLEASE PRINT

Today's Date _____/_____/______ Level Of Commitment: **Temp Relief** 1 2 3 4 5 6 7 8 9 10 **Wellness** Sex: □ M □ F

Name_____________________ How do you wish to be called? ______________

Birth Date: ______________Age ________ Ht ________ Wt _________ **I have had:** □ Acupuncture □ Homeopathy □ Chinese Herbs

Address______________________City___________________ State ______ Zip__________

Email: __________________________ Website ______________________

Tel # Day______________Ext.________**Eve**______________ext_______ **Cl Ph** ______________

SS# ____________________ May I leave a message on a recorder; or with someone else? □ Yes □ No Initial ___________

Place of Birth____________Occupation____________Religion/Spiritual Practice ____________ Car Make/Model/Yr______________

Marital Status: □Single □Married □Separated □Divorced □Widowed □Living with Partner ________________Pets ____________

Employer Name Address Phone# ______________________________

Emergency Contact Name & Tel #______________________________

Referred by ____________________ □ YPages, □ Newspaper, □ Radio, □ TV, □ Inet, □ Mag □ Other ____________

Date of Last Physical ____________ Diagnosis? ______________________

Dr's or Therapists Name(s) & # ______________________

Treatments you have/are receiving for this and/or other conditions?______________________

What do you desire to be treated? ______________________

Initial Cause? ______________________

When did this condition Start (Date)? ____________ Time of day/night it came on _________ Work Related □Yes □ No □ Don't Know

The Onset was □ Sudden □ Gradual □ Getting worse Interferes with □Sleep □Work □Play Worst thing about it ______________

What does the pain/symptom feel like? □ Sharp □ Dull □ Ache □ Pressure □ Shooting □ Radiating □ Pulsating Other ____________

What makes it worse? □ Heat □ Cold □ Wind □ Damp □Activity □ Rest □ Emotions □ Stress □ Environment □ Pressure Other __________

What makes it better? □ Heat □ Cold □ Wind □ Damp □Activity □ Rest □ Emotions □ Stress □ Environment □ Pressure Other ___________

What else was happening when it **first appeared**? ____________________ Did Grief or shock precede it? □ Yes □ No

When does it happen? ____________________ What does it look/feel like? ____________________

Do any other symptoms occur immediately before, during or after? ____________________

Do they tend to occur or become worse □daily □weekly □alternate days □ yearly □new □full moon □Barometer changes Other ________

Allergies To: □ Airborne Particles □ Food □ Drugs □ Other Explain ____________________

YOUR PAST Medical History

Do you currently have an infectious dis-ease? □ Yes □ No □ DK □ Pacemaker □ AIDS/HIV+ □ Hepatitis A B C □ Pregnant

□ Measles □ Alcoholism □ Scarlet Fever □ Blood □ Plasma Transfusions □ Bleeding Tendency □ Warts

□ Herpes □ Concussions □ Chickenpox □ Whooping Cough □ Convulsions □ Adrenal Exhaustion

□ Mumps □ Eczema □ Rheumatic Fever □ Chemical Sensitivity □ Transplant □ Implants

Exposure to: □ Chemicals □ Heavy Metals □ Acid/Alkalines □ Electrical #TV Hours/week ________ Other _______

Computer Hrs/wk. _______ Estimate How many X-Rays in your lifetime Dental ___ Body ___ CT Scans _____ MRI's _____

Your General Health as a **Child** □ Excellent □ Good □ Average □ Poor **Now** □ Excellent □ Good □ Avg □ Poor

Yearly Flu Shot? □Y □ N Any bad reactions to vaccines? □Y □ N □ Don't Know If so which ones ______________

Describe any surgeries, significant injuries, chronic or major illnesses, accidents, hospitalizations and the dates: Use back

____

I have never been well since ____________________**Did you serve in the Military?** If yes, where? ______________

When? ____________ How long did you serve? ______ contract any illnesses while serving? Y / N If yes, what? ______________

Name:________________________ If you have experienced these symptoms in the last 3 months Circle If before that use √ Mark

Cardiovascular

Conditions

□ Heart Disease
□ Short of Breath
□ Hi □Lo Blood Pressure
□ Feet Swelling
□ Chest Pain
□ Palpitations □ Irregular
□ Arteriosclerosis
□ Varicose Veins
□ Edema □ Fainting
□ Other _____________

Immunity

□ Slow Wound Healing
□ Easy Bruising
□ Chronic Infections
□ Frequent Allergies
□ Lupus □ Lyme's Ds
□ Fibromyalgia
□ Hay Fever □ Candida
□ Yeast Infections
□ Anemia
□ Mono □Epstein Barre
□ Other _____________

Respiratory

□ Pneumonia □ Pleurisy
□ Asthma □ Wheezing
Worse □Inhale □Exhale
□ Difficulty Breathing
□ Emphysema
□ Persistent Cough
□ Phlegm □ Blood
□ Tuberculosis
□ Shortness of Breath
□ Frequent Colds/Flu
□ Other _____________

Habits:

Type of Exercise: ________________________________
How Often ________________________________
Smoke #/Day______ How Long ____Yr Quit _______
Recreational Drugs________________________________
Alcohol Use ________________________________
Energy: □ Normal □ Problem □ Hi □ Low
□ Up and Down □ Exhausted □ Hyperactive
□ General Fatigue □ Chronic Fatigue
□ Sudden Energy Drop □Energy Level 1 Low-10Hi ___
Time **Highest**____ □am □pm **Lowest** ____□am □ pm
□ Other ________________________

Musculo-Skeletal

□ Muscle Spasms □ Cramps
Pain: □ Neck □ Shoulder
□ Arm □ Wrist □ Fingers
□ Hands □ Chest □Abdom
□Upper □Mid □Low Back
□ Joints □ Muscle Pain
□ Knee □ Leg Pain
□ Foot □ Toe Pain
□ Arthritis □ RA
□ Osteoporosis □ Gout
□ ________________

Endocrine

□Goiter □ Hypoglycemia
□ Diabetes Type □ I □ II
□ Hypo □Hyper Thyroid
□ Hormone Problems
□ Type used__________
□ ___________________

Head, Eye Ear, Nose & Throat

□ Impaired Vision
□ Eye Pain/Strain
□ Glaucoma □ Floaters
□ Glasses □ Contacts
□ Tearing □ Dryness
□ Impaired Hearing
□ Ear Ringing □Hi □Low
□ Earaches
□ Mouth □ Face Sores
□ Headaches
□ Sinus Problems
□ Nose Bleeds
□ Teeth Grinding
□ Frequent Sore Throats
□ TMJ / Jaw Problems
□ Bad Teeth □ Gums
□ ___________________

Genito-Urinary Tract

□ Kidney Disease
Stones: □ Kidney □Bladder
Urination □ Freq □ Painful
□ Dribbling Urination
□ Scanty □ Frequent UTI
□ Urgent □ Incontinence
□ Blood in Urine
□ Discharge
□ Genital Sores □Herpes
□___________________

Neurological

□ Vertigo/Dizziness
□ Paralysis □ Tremors
□ Numbness / Tingling
□ Loss of Balance
□ Seizures / Epilepsy
□ Dyslexia □ Stroke
□____________________

Sleep Pattern

□ Normal □ Insomnia □ # Hours _________________
□ Deep □ Light □ Restless □ Bad Bedtime __________
□ Hard to go to sleep □ Hard to wake up
□ Wake to early □ Need daily Naps
□ Wake-up □ Refreshed □ Tired
□ Slow starting □ Need Stimulants
□ Sleep Apnea □ Drooling
□ Grinding/ Clenching teeth
□ Night Sweats □ Start □ Middle □ End
□ Sleep Position(s) □ Toss and turn
Start ________________________________
Waking ________________________________
□ Vivid Dreams □ Nightmares
Re-Occurring Dreams (Themes) _________________
____
____
Any position can't sleep in ________________________
□ ________________________________

Men Only □ Cancer □ Any complaints or sexual disturbances? ________________________________
Desire for sex □ Aversion □ Low □Excessive Masturbation □Excessive Desire ________________________________
Sexual abuse □ Yes □ No **Pain** □ Yes □ No □**Itching** where and describe: ________________________________
□Swelling or Lumps (where) ________________________________ □Want pressure □No pressure
Prostate: PSA level______ □Prostatitis □Inflammation □Congestion □ED/Impotence How often ____________________
Penis □Blood □Mucous □Discharge (color) ___________ □Abnormal Erections □ Seminal discharge color _________ □Warts □Rashes
□Spots □Nocturnal Emissions □ STD □Complaint or problem with intercourse? ________________________________
________________________________ □ Other ______________□ Hormones □ Viagra □ Saw Palmetto

Women Only: ***(Please indicate current or previous period conditions, even if now Menopausal)***
Are you pregnant right now? □ Yes □ No □ Trying □ Maybe □ Infertile **Method of Birth Control** ____________________
Age at first period _________ **Date of last menses** _________ **Age/yr Menopause** _________ **Hysterectomy Date**: ______________
□ Ovaries Removed □Tubes Tied **Date:** ___________**# of Pregnancies** ________ Births _______ Abortions _____ Miscarriages _____
Typical length of menses (days) ________**Typical length of cycle** from 1st day to 1st day of menses __________ □ Fibroids □ Cysts
Bleeding □Regular □ Irregular □ In-between Spotting. **# Tampons/ Pads** per day _____ Per night _____ □ Heavy Flow □ Scanty Flow
Painful Periods □ Before □ Middle □ End □ After □Want pressure □No pressure **Menses Color:** □Pale □Bright □Dark □Purple □Red
□Brown **@:** Start ________Middle _______ End _________ □ **Clots** □Hot Flashes **Emotion Around Period** □ Normal □ Abnormal
□ Crying □ Depressed □ Irritability □ Anger □ Sadness □Other ______________□**Low Libido** □**Excessive Libido** □**Painful Intercourse**
Vaginal Discharge □ Normal □ Abnormal Color ________________ Consistency ________________ Smell _________________
□**Prolapse**__________ **(Peri) Menopause Symptoms** ________________________________
Breast □ Lumps □ Tenderness □ Heaviness □ Comes and goes with cycle □ **Nipple** Discharge color ________________□ Deviation
□ Cancer ______________□ **Hormone Use** Type _________________How Long ______Anything else? ________________________

Name: ________________________ **If you have experienced these symptoms in the last 3 months Circle If before that use √ Mark**

□Rt □Lft Handed. **Blood Type** ________ **Time seems to** Pass □ Normally □ Too Quickly □ To Slowly

Do you tend to get sick in a season year after year? □Y □ N Which one(s) ______________________________

If you get ill or injured the side of the body most affected is: □R □L □Both □R to L □ L to R □ Don't Know.

On injured/sick parts: □Better □Worse **Cold** □Better □Worse **Warm** □Better □Worse **Hot applications** □Don't know

Dislike: □ Tight Clothing □ Ties/Collars □ Belts **Time Complaints usually come on** ___________ **last until** ___________

Usual Body Temperature _____F Do you have **Chronic Fever**: □Low □Hi □ Alternates daily or weekly (Tidal Fever)

□ I Feel cold easily □ Cold hands □ Cold feet □I Feel Hot easily □ Hot hands □ Hot feet □ Alternate feeling hot and cold

Prefer Thermostat set @ ______ **Why?** _____________ **Wear most of the time** a □Hat □Sweater □ Coat **Why**? ________

Sensitive to: □Cold □Hot □Humidity □Damp Conditions (House, Outdoors etc) □ Dry climate □Light □Noise □ Sun

□ Drafts or Windy Conditions □ Uncovering □ Extreme temperature changes □ **Weather changes (Barometer):**

□Hot to Cold □AC to Summer Heat □Cool Nights with Hot Days □ **I Need Fresh Air/Fan** □ **It can be stuffy.**

I am □Better □Worse **Outdoors** Why _________________ **Other** ______________________________

Environment / Travel Do you desire to travel? □ Y □ N Where to ______________________________

I am □ Better □ Worse **Mountains** □ Better □ Worse **Seashore** □ Better □ Worse **Desert** **Often travel?** □ Yes □ No

Mental /Emotions: How do you perceive yourself? □Normal □ Problem □ Recent change in Emotions

Predominant Emotion: □ Joy □ Fear □ Anger □Anxiety/Worry □Sadness □Shock □Grief **Below:** Check all that apply:

I Am:		**Emotionally I Feel?**		**I have had**	**Poor memory for:**		**Do you Dwell on:**	
□ Outgoing	□Extrovert	□Happy	□Irritable □Sad	□Panic attacks	□Words	□ Places	□Past disagreements	
□ Introvert	□Restless	□Grieving	□Joyless	□Depression	□Where going		□Misfortune	□Illness
□Ambitious	□Driven	□Fearful	□Angry	□Anxiety	□ Doing	□People	□Business	□Cancer
□ Jealous	□Dreamer	□Indifferent	□Loathe Life	□Bad Temper	□ Train of thought		□Suicide	□Death
□Suspicious	□Timid	□Impulsive	□Moody	□Phobias	□ Omit letters words		□Future Events	

I am **B**etter **W**orse □B □W Thunderstorms □B □W Consolation □B □W Alone □B □W Crowds □B □W Contradiction

□ Run arguments in your head repeatedly □Nervous □Difficult concentration **I am afraid of**: ______________________

When is it worse? ________ Where do you hold stress in your body? __________ How do you relax?____________________

How do you feel about your Work?______________ Home life? ______________ Social life?____________ What was your

Growing up like? □Good family home □Abuse Survivor? □Physical □Sexual □Emotional □Spiritual? Explain _______________

____

How did you cope with the first loss of something you loved? ______________________________________

If you were guaranteed success and money and time were not obstacles, what would you like to do with your life?

____

Appetite and Digestion □ Normal □Abnormal □ Bulimic □Anorexic □ Poor appetite □ Nausea □ Bloating □ Gas

□ Rapid hungering □ Hungry but no desire to eat □ Indigestion □ GERD □ Ulcers Other ______________________________

Are you on a special diet (Vegan, Vegetarian, Low carb, Raw, Atkins, Zone, South Beach? describe ______________________

What foods do you Crave whether you eat them or not? ________________ **Comfort Foods** ______________________

Aversions/Dislikes: _______________________ **Food Allergies or Intolerances**_____________________________

Crave which of these tastes**:** □Salty □Sour □Bitter □Sweet □Spicy □Smoked **Avoid:** □Salty □Sour □Bitter □Sweet □Spicy □Smoked

Describe Any Digestive troubles ____

Describe meals for a typical day:

Breakfast____Lunch_____________________________________

Dinner____ Snacks ____________________________________

How many x week do you have: Meat ____ Veggies ____Dairy _____ (□milk □cheese □yogurt □ice cream) _____ Soy ____Fish _______

Chicken _____ Caffeine ____ Artificial Sugar ____ Soda ____ Sugar/Sweets _____ Processed Foods _____ Sushi ___________

Cups/Glasses: Water _____ Coffee ____ Alcohol _____Tea _____ Soda ______ Juices____ Soy Rice Milk ___ Prefer to drink ______

Thirst □Increased □Decreased □Always Thirsty □Thirsty w No Desire to Drink □No Thirst. **Prefer** □Freq Small Sips

□ Large Sips □Gulps **You usually prefer drinks** □Hot □Warm □Room Temp □Cold □Iced or □Lots of Ice □ Chew Ice

Name:__________________________ If you have experienced these symptoms in the last 3 months Circle If before that use √ Mark

Bowel Movement □Normal □Abnormal **Time of Day** _______ **# Times daily** _____ # Inches ______ □ Float □ Sink
□ Constipation □ Diarrhea □ Loose □ Watery □ Incomplete □ Hard and Dry □ With Mucus □ With Blood □Pellets
□ Alternate Diarrhea/Constipation □ Incontinent □ Strong Smell Color _________________________________ □ Hemorrhoids □ IBS
□ Colitis □Itchiness □Anal Fissures □ Painful When ______________________________ Other ____________________________________
□ **Urinate x day** ______ Night ______ □ Incomplete Burning: Before □ During □ After Other ____________________________________
Sweating □ Normal □ Abnormal □ To much □ Too little □ With little exertion □ Hot flashes □ Night sweats □ Difficult _______________
Use □Antiperspirant □Deodorant **Smells** □Strong □Offensive □No Odor □Sweet Odor □Garlicky □Violets Other ____________________

Skin, Nails & Hair:
I have or often have □Dry Rough □Oily □Combo Skin □Warts □ Eruptions □ Skin Rashes □Hives □ Itching □ Acne □ Rosacea □ Eczema
□ Psoriases □ Moles □ Skin Tags □ Easy Bruising □ Scars □ Varicose Veins □ Vitiligo □ Other _________________________________
□ **Hair loss** at age _________ where ________________________ Fell out □ Gradually □ Quickly □Bunches □Spots □Patches □ All over
After □ Illness □ Heredity □ No apparent cause □ Premature graying where ____
Scalp □Shiny □Dull **Hair** □Dandruff □ Dry/Brittle □Mats □Glossy □ Healthy □ Colored Other:___________________________________
Finger Nails: □Brittle □Thin □Thick, □Ridges V H □ Pitting □White Flecks □ Spoon Shaped □Moons □Yellow □Fungus □Hangnails
□Fissures Color: □Blue, □Pale, □Pink, □Red, □Yellow, □White, Healthy Looking Y N Hands/Fingers □ Calloused
Toenails: □Brittle □Thin, □Thick, □Ridges V H □Pitting, □White Flecks, □Spoon Shaped, □Moons, □Yellow □Fungus □Hangnails
□Fissures □Ingrown toenail Color: □Blue □Pale □Pink □Red □Yellow □White □Healthy Looking □Soles/Toes Calloused □ Corns

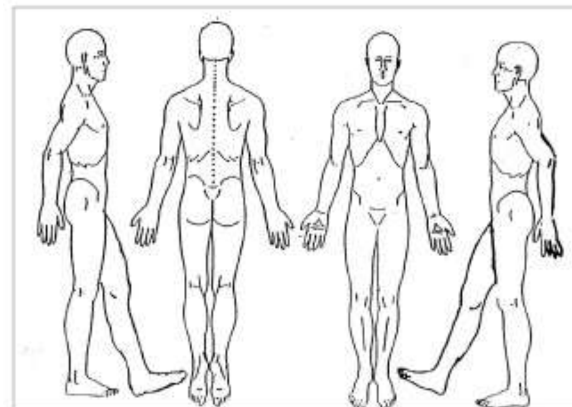
Mom's Pregnancy: Please state (*if known*) the health of your mother when she was pregnant **with you** □Not Known Did she suffer from □Vomiting □ Anemia □ Toxemia □Hi blood pressure □ Diabetes □Smoke □Drink □ Take recreational Drugs □ Rx Med □ DES □The Pill (before getting pregnant) Did she experience any □Emotional □Physical trauma or any other problems during her pregnancy ____
Was your Own birth: □Normal □Difficult □Long ______ hrs □Breech □Forceps □Premature _______ wks □Cesarean
□Induced Labor **Were you Breastfed?** □Y □N □ Don't know If Yes For how long ______________________________________
□**Birth Traumas/ Defects** ____
# of biological Brothers: ________ Sisters: ________ Were you adopted? □ Yes □ No Your place in the birth sequence #: ____________
Did you feel safe and nurtured as a child? □ Always □ Usually □ Sometimes □ Never □Vaccinated? Bad reactions □ Y □ N
First Illness ____________________________________ @ age_______ Treated w ____
You got over it □Quickly □ Slowly □ Don't Know Did you get it often? □Yes □ No □ Don't Know

FAMILY Medical History *Please give as much detail as possible of overall health and major illnesses and List the present age or the age at death of each of the following members of your family, also if living add if their health* is **G**ood, **F**air, or **P**oor. **D**eceased

Overall Health Birthdate/Age Occupation Specific Ailments If Passed Away Cause of death

Mother: G F P D ____
Father: G F P D ____
Sibling: G F P D ____
Sibling G F P D ____
Sibling G F P D ____
Maternal**: Grandma** G F P D ____
Grandpa G F P D ____
Paternal **Grandma** G F P D ____
Grandpa G F P D ____

Did any of them have □ AIDS/HIV □ Gonorrhea □ TB □ Syphilis □Chlamydia □Heart Problems □ Asthma □Strokes □Diabetes □Arthritis □ Moles □ Warts □ Skin Problem □ Mental Illness □ Suicide □ Cancer of ____________________ □ Learning Disabilities Are there any hereditary diseases in your family? If yes, please list ___________________________________ Please Mark Any Areas of Pain or Injury
Anything I did not ask that is bothering you? Explain: _____________________
What are your expectations from my treatment modalities? ________________
____



Leave blank

Cause __________________ Type of pain __________________ Char______________________
Loc ____________________ Mod _________________________Concts______________________
Key ____________________ Ess ________________________ Tot______________________
Remedy _____________________________ Sat ____

Abundant Health Holistic Center

Solara Attatharya, DOM, AP, DNBHE
352 365-4325

Please Print as you fill it out

PATIENT NAME ____ Date ____________

What medications are you taking? (□Rx, □Over The Counter, □Aspirin, □Anticoagulants, □The Pill, □Hormones, Vitamins, Herbs, greens, probiotics, power bars, drinks including energy drinks, etc.
and Please check if prescribed by a **Physician** (**Rx**) or **Self** prescribed (**SRx**) Include Mfr and dosage.

	Medication / Supplement	Dosage	Frequency	Condition	Brand Name	Working?
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N

"Anything" else you take only sometimes or recently stopped taking and why

☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	____________	______Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	__________________	Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	__________________	Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	__________________	Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N
☐Rx ☐SRx	__________________	Mg	______ X Day	For ____________	Mfr ____________	☐Y ☐N