# MOLLY BROWN
HOLISTIC HEALTH & WELLNESS

Welcome! We are ready to help you begin your journey towards better health. Your initial consultation will begin this process. Here are our goals:

1. To do the appropriate testing on each patient in order to find the root cause of their condition.
2. To address your health challenges and return you to the most optimal state of health possible.
3. To determine if you are a good candidate for care in our office and if so begin care as soon as possible.
4. To answer any questions you have regarding your health condition.

Payment Policy:
Molly Brown Holistic Health is a "fee for service" practice and payment is due at the time of service. We accept cash, check or credit card.

Initial Exam Payment and Policies:
Your credit card will be charged $100 to hold your appointment time.
We require 48 hours notice for cancellations or the $100 holding fee will be charged without reimbursement.
Do not consume any nutritional supplements the day of your appointment. Continue taking all prescription medications.
Please arrive at least 5 minutes early to your initial appointment.
We thank you for this opportunity to provide you with our health and wellness services and look forward to meeting you.

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# Confidential Health History

DO NOT TAKE ANY NUTRITIONAL SUPPLEMENTS ON THE DAY OF YOUR EXAM

Referred by:_____
Occupation or Profession: _____
Name:
_____
Address: _____
_____ State: _____ Zip:_____
Phone:
(home) _____ (work) _____ (cell) _____
Email:
_____
Birth date: ____/____/_____ Age: _____
Sex: __M __F
Marital Status: __Single __ Married __ Divorced __ Widowed
No. of Children: _____
Please complete the following form carefully. The information you provide will help us to build a personalized wellness program for you. All information is strictly confidential. Click on an empty line to type in your information. Click on a box or short line to create a check mark.
Please list your current health conditions, concerns or symptoms that are bringing you to our clinic beginning with the condition of most concern.

1._____

2._____

3._____

4._____

5._____

Current medication/supplementation_____

What surgeries, operation, traumas, accidents have you had?
_____
_____

**Condition #1**_____DateNoticed:_____
How did this condition begin?
_____
Have you had this condition in the past? __Y __N

How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing

Frequency of symptoms: __ Constantly (76-100% of day) __ Frequently (51-75%)
__ Occasionally (26-50%) __ Intermittent(0-25%)

Rate the pain or severity of the condition (1= minimal 10 = excruciating)
__1 __2 __ 3 __4 __5 __6 __7 __8 __9 __10
What activities aggravate your condition?_____
What therapies or activities help to relieve the condition?_____
Who have you seen for this condition or symptom? Name:_____
Diagnosis: _____Treatment:_____

**Condition #2**_____DateNoticed:_____
How did this condition begin?
_____
Have you had this condition in the past? __Y __N

How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing

Frequency of symptoms: __ Constantly (76-100% of day) __ Frequently (51-75%)
__ Occasionally (26-50%) __ Intermittent(0-25%)

Rate the pain or severity of the condition (1= minimal 10 = excruciating)
__1 __2 __ 3 __4 __5 __6 __7 __8 __9 __10
What activities aggravate your condition?_____
What therapies or activities help to relieve the condition?_____
Who have you seen for this condition or symptom? Name:_____
Diagnosis: _____Treatment:_____

**Condition #3**_____DateNoticed:_____
How did this condition begin?
_____
Have you had this condition in the past? __Y __N

How is your condition changing? __ Getting Better __ Getting Worse __ Not Changing

Frequency of symptoms: __ Constantly (76-100% of day) __ Frequently (51-75%)
__ Occasionally (26-50%) __ Intermittent(0-25%)

Rate the pain or severity of the condition (1= minimal 10 = excruciating)
__1 __2 __ 3 __4 __5 __6 __7 __8 __9 __10
What activities aggravate your condition?_____
What therapies or activities help to relieve the condition?_____
Who have you seen for this condition or symptom? Name:_____
Diagnosis: _____Treatment:_____

**Health History:**
Type of birth: __ C-Section __ Normal __ Forceps Adopted: __ Yes __ No
Birth Order: ___ of ___

List, according to age and occurrence from infancy to present age: all sicknesses, disease, injuries, hospitalizations and surgeries. Please include any major dental work.
Infant - Age 12
_____
_____

Age 12 – 30
_____
_____

Age 30 – 50
_____
_____

Age 50 +
_____
_____

Medications you are currently taking: (If more than 8 please list on the last page under NOTES)
1._____: __ Less than 3 months__ 3 months to a year__ Over a year
2._____: __ Less than 3 months__ 3 months to a year__ Over a year
3._____: __ Less than 3 months__ 3 months to a year__ Over a year
4._____: __ Less than 3 months__ 3 months to a year__ Over a year
5._____: __ Less than 3 months__ 3 months to a year__ Over a year
6._____: __ Less than 3 months__ 3 months to a year__ Over a year
7._____: __ Less than 3 months__ 3 months to a year__ Over a year
8._____: __ Less than 3 months__ 3 months to a year__ Over a year

Medications you have taken in the past but are not currently taking:_____
_____

Nutritional Supplements: Please list all vitamins, herbs, minerals or other food supplements you are currently taking and how often.

_____
_____
_____

Allergies: Please list all known allergies.

_____

Do you have pets? __ Yes __ No Type and number_____
Are any of these pets allowed on your bed? __ Yes __ No

**Stress:**
Please rate your current level of stress from 1 to10 (1 = none 10 = unbearable):_____
Please list the 5 most stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life or your health?

1._____
2._____
3._____
4._____
5._____

What steps are you taking to reduce your stress levels?

_____

Have you recently had full-body anesthesia? __ Yes __ No
Do you have breast implants? __ Yes __ No
Do you have body piercings or tattoos? __ Yes __ No
Have you had elective surgery? (tummy tuck, face lift, mole removal, etc.) __Yes __No
Do you have any internal metal or plastics? (pins, stints, screws, plates, etc.) __Yes __No
List location and type of implants:

_____
_____

**Sleep:**
How well do you sleep? (Check all that apply)
__ I sleep very well __Restless __ Difficulty falling asleep __ Difficulty staying asleep
__ Bad dreams __ I wake feeling rested __ I wake feeling tired __ It is hard for me to get out of bed

How many times per night do you wake up?_____
What time do you usually go to bed?_____
How many hours of sleep do you get per night?_____
How many times per night do you get up to urinate?_____
Do you have a television in your bed room? __ Yes __ No

Type of bed:__ Spring __ Sleep number __ Foam __ Water __ Natural rubber foam __ Other:_____

**Exercise:**
(Check all that apply)
I exercise:__Daily __3-5 times per week __1 to 3 times per week __Once/week __Never

Types of Exercise I do: __ Yoga __ Cardio __ Weight Lifting __ Cross training__ Running __ Walking__ Swimming __ Biking __ Personal trainer __ Other:_____

**Water:**
Do you drink tap water?__ Yes __ No
Do you use a water filter at home?__ Yes __ No If yes, what type:_____
Do you buy drinking water for your home?__ Yes __ No If yes, what type:_____
Do you have a water softener in your house? __ Yes __ No
Do you have a whole house water filter?__ Yes __ No

**Air:**
Do you have a home air purifier? __Yes __ No __Type:_____

**Tobacco:**
Do you currently smoke or use tobacco? __ Yes __ No Daily amount:
_____
Have you used tobacco in the past? __ Yes __ No When and how long?_____

**Alcohol:**
I drink:
__ Beer __ Wine __ Hard Liquor
__ Less than one drink per week __ 1-2 per week __ 3-5 per week __ More than 5 drinks per week
__ I do not currently drink alcohol __ I am in alcoholics anonymous

**Eating Habits:**
Do you: __ Skip meals often __Have irregular eating times __ Eat food after 9pm
What percentage of the meat you purchase is organic? _____ %
What percentage of the produce you purchase is organic? _____%
I eat at fast food restaurants ____ Never __ 1-3 time per month __ once per week __ 1 -3 times perweek__ 3-5 times per week__ Daily
How manydays
per week do you cook or heat your food in a microwave?
__ Never __1 __2 __3 __4 __5 __6 __7

**Food Stressors:**
Please check the foods you consume with some regularity:

| **Stimulants** | **Toxic and Rancid Oils** | **Commercial Dairy** | **Processed Carbs** |
|---|---|---|---|
| __Coffee | __Fried foods | __Cow's milk | __Bread |
| __Black tea | __Fast food | __Yogurt | __Crackers |
| __Soft drinks | __Potato chips | __Ice cream | __Bagels |
| __Diet soft drinks | __Mayonnaise | __Cheese | __Pastries |
| __Chocolate | __Peanut butter | __Cream | __Cookies |
| __Candy or sweets | __French Fries | __Pasta | __Corn Chips |
| | | | __BreakfastCereal |

Other information regarding your diet:
_____
_____

**Toxic Exposure**
**Work:**
Are you exposed to any toxins at work? __ Yes __ No What type?_____

**Recreational Drugs:** This information is strictly confidential Do you use drugs: __ Now __ In the past At what age? _____ Type?_____

**Personal care and home products:** Check all that you use
__Hair permanent __Antiperspirant __Facial make-ups __Hair spray __Hair gel __Air freshener sprays __Air freshener plug-ins __Dryer Sheets __In house bug sprays
__Hair colors __Fingernail polish __Perfume / Cologne __Lawn fertilizer (non-organic)

**Electromagnetic Exposure:**

Do you live or work less than 3 blocks from high voltage power lines?
__ Yes __ No
Do you sleep with analarm clock closer than 6 feet from your bed?
__ Yes __ No
How many hours per day do you use the following?
____ Television ____ Computer ____ Cell Phone ____ Electric Blanket
____ Car (Other vehicle) ____IPad / Tablet

Please check all that you are currently experiencing:

**Musculoskeletal System**
___ Neck Pain___ Pain between shoulders___ Shoulder pain___ Muscle weakness___ Low back pain___ Arm problems___ Leg problems___ Swollen joints___ Painful joints___ Stiff joints___ Sore muscles___ Walking problems

**Gastro Intestinal System**
___ Poor appetite___ Excessive hunger___ Difficulty chewing___ Difficulty swallowing___ Excessive thirst___ Nausea___ Vomiting food___ Abdominal pain___ Diarrhea___ Constipation___ Black stools___ Blood in stool___ Hemorrhoids___ Heartburn

**Cardio–Vascular–Respiratory**
___ Chest pain___ Pain over heart___ Difficulty breathing___ Persistent cough___ Coughing phlegm___Coughing blood___ Rapid heartbeat___ High blood pressure___ Low blood pressure___ Varicose Veins___ High cholesterol

**Nervous System**
___ Numbness___ Loss of feeling___ Dizziness___ Fainting___ Headaches___ Muscle Jerking___ Forgetfulness___ Confusion___ Depression

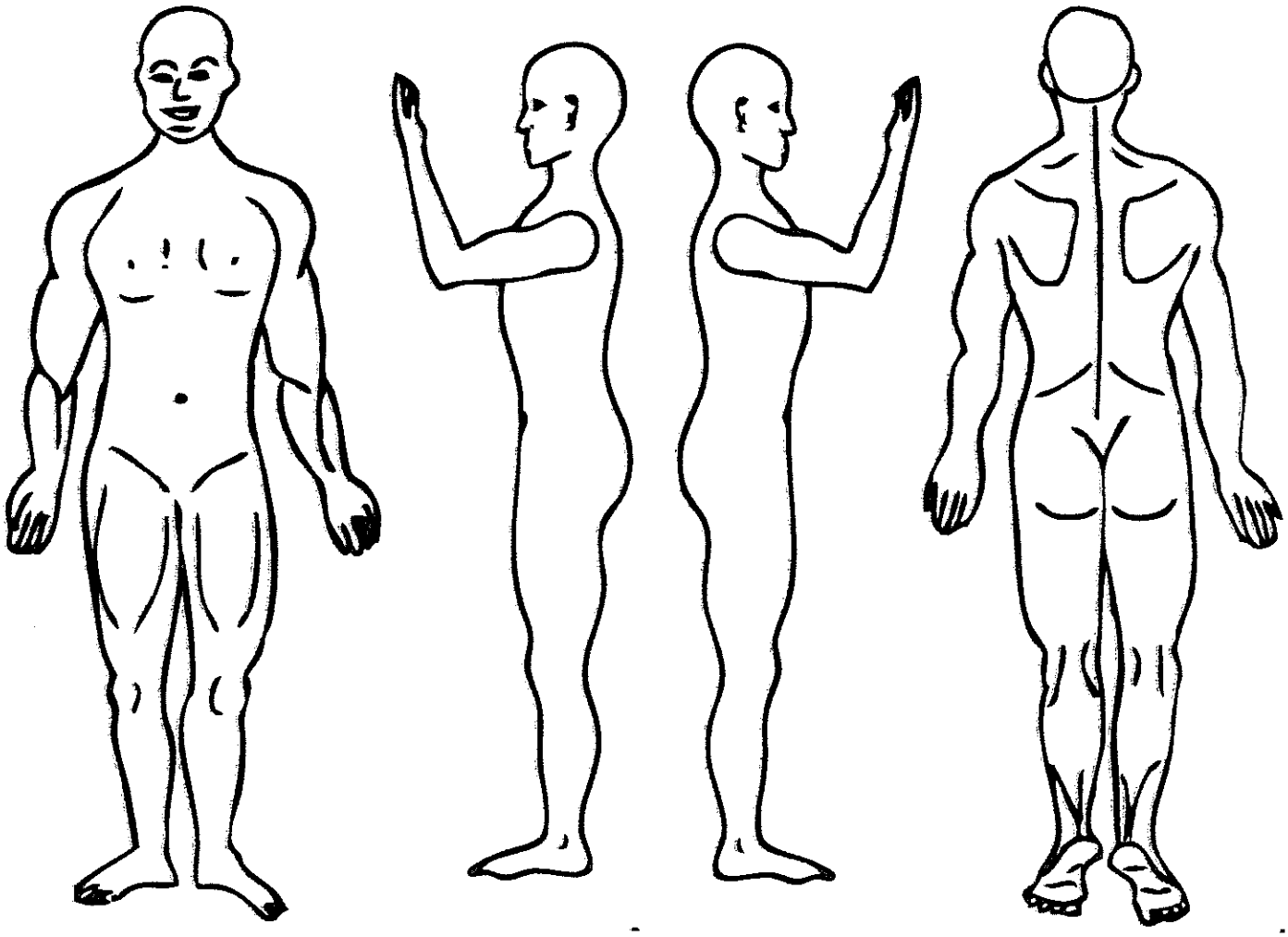
**Urinary System**
___ Excessive urination___ Scanty urination___ Painful urination___ Discolored Urine___ Frequent UTI's

**Bowel Function**
How many bowel movements do you average per day? __1 __2 __3 __4 __5 __ More than 5__ Every other day __ Every 3 days __ Less

# Scar/Trauma Chart

Name: _____

Date: _____



***Directions***

**All Scars.** Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, all injection sites (no matter how long ago), old burn areas, etc.

**All Trauma Areas.** Please put a red X where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

**Internal Metal:** Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

**Date of injury and type of injury.** Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988.")

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