# Holistic Nursing Assessment Form

Adapted from Seeds & Bridges Holistic Nurse Access Tool (1996)
and Bodymind Systems Self Assessment tools (1987)
A service of Holistic Nursing Consultants - Barbara Denison MSN, ARNP, AHN-BC

**Name: _____DOB: _____ Age: ____**
**Gender: __ Address: _____ Phone: _____**
**Email: _____Marital Status: _____ Children:**
_____
**Occupation/Profession: _____**

**Formal education completed: _____**

**Family of Origin:** (who raised you, still living? siblings?)
_____
**Medical Diagnosis:** (if appropriate)
_____
_____
_____
_____
**Hospitalizations:** (when & for what, include surgeries):
_____
_____
_____
_____
**Healthcare Provider(s):**
_____
_____
**Allergies:** (known) _____
**Food sensitivities:** (known)_____
(suspected) _____
**Medications:**
_____
_____
_____
_____
**Supplements:** (herbs/botanicals/vitamins/minerals/nutrients )
_____
_____
_____
_____

**Current health problem(s) leading you to seek consultation:**

_____
_____
_____
_____
_____
_____

**Physical Health Patterns:**

1. How many glasses of water do you drink a day on average? _____
2. How many servings of fruits do you eat a day? _____
3. How many servings of vegetables do you eat a day? _____
4. How many servings of meat and/or fish do you eat a day? _____
5. What do you eat as your sources of protein? _____
6. How many servings of dairy products (cheese, milk, yogurt) do you eat a day? ___
7. How many servings of grains (bread, pasta, rice) do you eat a day? ____
8. How many sweets/sugar containing foods/beverages do you consume daily? ____
9. How many caffeine beverages do you consume daily? (list coffee separate) ____
10. How many servings of fried food do you consume daily? _____
11. Do you routinely salt your food? _____
12. Do you buy organic food whenever possible? _____
13. How many hours do you sleep a night on average? _____
14. Do you tend to sleep more on your right or left side? ____
15. Do you have difficulty getting to sleep or wake up during the night? _____
16. If yes to #15, what do you use as or do for sleep aids? _____
17. Do you wake up refreshed or tired? (please circle)
18. Do you remember your dreams? ____
19. Do you have enough energy to work and do household chores? ____
20. Do you smoke? ____ If yes, how much? ____
21. Do you drink alcoholic beverages? _____ If so, how much on the average per week and what? _____
22. How much exercise do you get a week (frequency & how long)? _____
23. Describe what type of exercise you do? _____
24. Do you routinely incorporate relaxation? ____
25. What frequency and type? _____
26. What do you do for your health maintenance? _____ _
27. Can you perform all your personal self care activities? (bathing, etc.) ___
28. What do you do for fun/pleasure? (hobbies, social activities, play)
    _____
29. How much sunlight do you get a day? ____
30. What condition are your nails? ___ Circle if you have white spots, ridges, weak or peeling nails.

31. How well do you eliminate? ____
32. How many bowel movements a day? ____ Circle if you tend to be constipated or have loose/diarrhea stools.
33. How often do you urinate? ___ Do you get up at night to urinate? ____
34. What color is your urine? _____ Circle if it's clear or cloudy.
35. Do you perspire with exercise? ____ Does it have a bad odor? ____
36. Circle any skin problems, eruptions, discoloration, dry, flaky, other
37. Do you bruise easily? ____
38. Do your gums bleed easily? ____
39. Circle if you have a problem with your hearing, ringing in ears, drainage.
40. Circle if you have problems seeing, wear glasses for reading or distance, blurry vision, double vision, see spots or unable to see in some of your field of vision.
41. Circle if you have a problem with drainage from nose, sinuses. What color is it? _____
42. Circle if you have a problem with your breathing, short of breath, hard to get breath, wheezing, cough up mucus regularly. What color is it? _____
43. Describe any persistent pain you may have, its location, duration, severity (using a scale of 1-10, with 10 being worst).
    _____
    _____
    _____
44. How many colds a year do you tend to get? ____ How long do they last? _____
45. When you get sick, what part of your body is usually affected? ___ How long do you take to recuperate? _____
46. Rate your ability to heal from cuts (1-10, with 10 healing fastest) ____
47. Circle if your feet, hands or ankles swell. When does it happen? ____
48. Are you aware of any swelling or tenderness in your lymph nodes? ____ (neck, groin, under arms)

**Emotional Health Patterns:**

1. How would you describe your emotional response to stress? ____
2. Are you aware of your feelings when involved in a difficult situation? _____
3. Would you say you tend to spend more time being (please circle) angry, lonely, depressed, sad, agitated, calm, at peace, loving, happy, joyful, fearful, anxious, nervous, numb to feelings? Or write in your predominate feelings _____
4. Describe how you feel when you perceive an injustice has been done or a situation has turned out unfair? _____
5. Do you tend to have a judgmental or nonjudgmental attitude? (circle)
6. Rate your ability to express your feelings (1-10, with 10 most able)____
7. Are you able to share your feelings without seeking the approval of others or fearing the outcomes? _____

8. Circle if you view feelings as guides, barometer, interference, none of these.
9. Are you satisfied with how you handle your feelings (rate 1-10) ____
10. Circle your response to illness or pain-
    acceptance, ally, enemy, anger, separate, connection, ignore, other
11. Do you tend to avoid situations or conversations that will stir up your emotions? ___
12. Please circle, do you tend to be a good listener or do you find yourself thinking of other things when someone is sharing feelings or thoughts? Other _____
13. Can you respect others feelings even if you don't agree with them?_____
14. Please circle if family/friends lifestyle is healthy or unhealthy.
15. Rate your satisfaction with the amount of social contacts you have (1-10, with 10 most satisfied) ____
16. Are you in an intimate relationship? _____
17. Rate your satisfaction with sexuality as part of this, or other, relationship (1-10) ____
18. Rate how you feel about yourself (1-10, with 10 most content) ____
19. Rate your body image satisfaction (1-10, with 10 most satisfied)____

**Mental Health Patterns:**

1. On a scale of 1-10, with 10 being most and 1 being least. Rate your perception of ability to move about doing activities of daily living. ____
2. Rate your perception of your flexibility ___
3. Rate your perception of your strength ___
4. Rate your perception of how much endurance you have with activities ___
5. Rate your perception of how much energy you have ___
6. Rate your perception of your dietary habits ___ (10 most satisfied, 1 least)
7. Rate your perception of your exercise habits ___
8. Rate the amount of stress in your life (1-10, with 10 most stress) __
9. Rate your ability to cope with stress (1-10, with 10 most able) ___
10. Rate the amount of change currently in your life (1-10, with 10 most)___
11. Rate your willingness to grow/learn from stress (1-10) ___
12. Rate your openness to considering new ideas (1-10) ___
13. Circle how you prefer to learn-auditory, visual, doing
14. What subjects do you like to read/learn about?
    _____
15. Do you tend to have interest and knowledge in many topics? ____
16. Rate your ability to complete new tasks that you begin (1-10) ____
17. Do you like to prioritize your work and set goals to accomplish them? ____
18. Are you willing to ask for help or suggestions when doing/learning something that you are unfamiliar with? ___
19. Are you able to follow through with tasks or plans you start? ___
20. Do you tend to procrastinate? ___
21. Circle if you enjoy or resist developing new skills and talents.
22. Do you believe that you have choices to change/improve your health or lifestyle? ___

23. Circle if you tend to be set in your ways of thinking/believing or are willing to use your imagination/creativity to consider new possibilities.
24. Rate your memory of recent events (1-10, with 10 best memory) ___
25. Rate your memory of events in the past (1-10) ___
26. Circle if your thought processes are clear or foggy.
27. Do you tend to be forgetful? ___
28. Rate whether you recognize your intuition (1-10) ___
29. Rate whether you tend to be a worrier (1-10, with 10 worry a lot) ___
30. Rate how much you use humor in interactions (1-10) ___
31. Do you think people are basically good? ___
32. Do you tend to be hurtful when you are angry at someone? ___
33. Circle if you see challenges as opportunities or obstacles.
34. Are you willing to say "no" when your plate is too full? ___
35. Are you able to say "no" when your plate is too full? ___
36. Are you able to make requests for what you need? ___
37. Are you able to share your opinions honestly without seeking approval of others or concern for the consequences? ____
38. Describe how you make decisions. _____
39. Rate your willingness to take risks to learn and grow (1-10) ____
40. Are you politically active (willing to accomplish something you believe in or are passionate about) ____
41. Do you recognize when circumstances are out of your control? ____

**Spiritual Health Patterns:**

1. Do you have a formal religion? ___ List if desired _____
2. Do you believe in a power higher than yourself? ____
3. Circle if you believe this power is <u>good/benevolent</u> or something to be <u>feared</u>.
4. Rate whether you perceive that all life has meaning. (1-10) ___
5. Circle if you believe in an <u>underlying order</u> within the universe or that events occur <u>randomly without purpose.</u>
6. What do you value in life?
   _____
7. What are your most valuable qualities when you are in touch with your Inner Self (feel most whole)? _____
8. What circumstances would be most helpful to allow these qualities to unfold?
   _____
9. What do you need to bring about these circumstances or best conditions into your lifestyle? _____
10. Are you aware at some level of a connection with the universe? ____
11. Circle if you are motivated by faith, love, fear.
12. Rate the importance of hope in your life (1-10) ____

13. Do you consider and/or value your intuition when making important life decisions? __
14. What practices or rituals do you perform to connect with your spirituality?
    _____
15. One definition of spirituality is the "personal experience of the divine". Have you experienced spirituality by this definition? ____
16. Do you feel your actions are congruent with values/beliefs? _____
17. Describe how your values/beliefs affect your health/health care.
    _____
    _____
18. What are your thoughts about death?
    _____
19. Would you consider yourself superstitious? ___
20. Are you involved in activity (ies) you feel contribute(s) to the betterment of humanity and/or world peace? _____ Describe if desired
    _____
    _____