Naturopathy Health Questionnaire

'Good Health – Naturally'

Please read carefully and take your time to fill out the questionnaire.

To help us to assist you, please fill in the following questions as accurately as possible. ***All information received is strictly confidential.*** Please forward the completed forms via email, post or fax, plus copies of recent blood tests, if available.

Please advise us as soon as possible if any of the information contained in this form changes in any way.

NAME Given		Surname	
ADDRESS			
EMAIL		DOB	
PHONE		FAX	
OCCUPATION		Hrs of Work:	

If under 18 years of age parent/guardian consent is required. Please write full name and sign below.

Name of Parent/Guardian:	
Sign:	

CURRENT HEALTH OVERVIEW

What health concerns brought you our clinic today?
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Current Medications

Please list all current medications (prescription and over-the-counter) and supplements (vitamins and herbs). If possible, also list dosage information and how long you have been taking the medication.

Medication/Supplement	Dosage	Duration

Allergies / Intolerances

Please list all known allergies (medications, food, environmental, chemical etc.)	

HEALTH HISTORY

Current Health Status

Height:	Weight:
Have you gained or lost weight lately? □ Gained (Yes or No): □ Lost (Yes or No): If so, please state how much:	

Please list your dietary intake over the last 24 hours:

Breakfast	
Morning Tea	
Lunch	
Afternoon Tea	
Dinner	
Snack	

Food groups avoided?	
Food cravings?	

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Do you use any of the following?

Substance	Form / Type	Amount per day
Alcohol		
Tobacco (cigarette)		
Recreational drugs		
Tea		
Coffee		
Soft drinks/Soda		
Water		

Please rate your average stress level on a scale of 1 to 10 (10 being the highest stress level)			
The cause of your stress			
Please rate your energy level on a scale of 1 to 10 (10 being the highest energy level)			
Worst Time:		Best time:	
Regular exercise?		Type of exercise	
Duration		Frequency	

Average hours of sleep per night?	

Please check (X) if you have any following sleep pattern.

	Wake up unrefreshed		Trouble falling asleep
	Trouble staying asleep		Wake often
	Wake early		Difficulty waking

Childhood Illness

Please check (X) all that apply and indicate approximate age of illness:

	Measles		Mumps		Rubella
	Rheumatic Fever		Scarlet Fever		Whooping Cough
	Chicken Pox		Chronic Ear Infection		Respiratory infections
	Tuberculosis		Other		

Immunizations? (Eg. Chicken pox, Polio, Flu etc.)

Medical History

Please list any hospitalizations and surgeries that you have had and when was it:

	When:
	When:
	When:

Family Health History

Mother		Father	
Siblings		Child(ren)	
Maternal Grandmother		Paternal Grandmother	
Maternal Grandfather		Paternal Grandfather	

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Do you suffer from any of the following symptoms or conditions (past or current)? (Please check (X) the box).

	Aches in Muscles or Joints
	Acidity
	Alopecia (Hair falling out)
	Amenorrhea (stopping of period if so how long since last one?)
	Anxiety
	Arthritis (Osteo or Rheumatoid etc)
	Asthma
	Blocked Fallopian Tubes
	Blood Pressure (High /Low)
	Bowel Problems - Constipation - Diarrhoea - Bloating
	Breast Problems
	Chronic Fatigue
	Cancers
	Candida
	Cervical Erosion
	Cholesterol
	Colds (recurrent)
	Colic (Flatulence, wind)
	Cramps
	Cystitis
	Dandruff
	Depression
	Digestive problems
	Discharges (other than period & ovulation)
	Dysmenorrhoea (painful period)
	Ear problems - Infections - Noises - Dizziness
	Endometriosis (How severe?)
	Epilepsy
	Eye problems (Conjunctivitis, Styes, Glaucoma, Cataract etc.)
	Fibroids (How large?)
	Fungal conditions
	Gall bladder problems
	Glandular problems
	Gout
	Hay fever
	Headaches (how frequent?)
	Heart problems
	Hernia
	Herpes
	Hirsutism (excessive hair growth)
	Impotency
	Insomnia
	Irregular periods (cycle lengths, days of flow)
	Kidney problems (including stones and fluid retention)
	Leukaemia
	Libido problems

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	Liver problems
	Menopausal problems
	Menorrhagia (flooding or clotting with period)
	Menorrhagia (Bleeding out of cycle)
	Migraines (other than simple headaches)
	Miscarriage (at what stage?)
	Moodiness (PMS or other)
	Mouth ulcers
	Nail problems
	Nausea
	Nervousness
	Ovarian problems (cysts etc)
	Over / Under weight
	Pancreas problems (diabetes, hypoglycaemia etc)
	Pill (have you been on a contraceptive pill – how long?)
	Prostate problems
	Respiratory problems
	Sciatica
	Sinusitis, Catarrh, Phlegm
	Skin problems (Acne, Dermatitis, Psoriasis, Rashes, Shingles)
	Salt cravings
	Sleepiness / Tiredness
	Sexually transmitted diseases (Current / Previous)
	Sperm problems (Count, motility, etc)
	Sugar cravings
	Spurs (Bone spurs or Osteophytes)
	Sweats (excessive)
	Teeth problems
	Testicular problems
	Thrombosis
	Thrush
	Thyroid problems
	Ulcers of any kind
	Vaginal problems (dryness, odour etc.)
	Varicose veins
	Vertigo (Dizziness)
	Warts
	Worms
	Other

Consent to Naturopathic Care

Naturopathic Medicine is a holistic approach to health care. Naturopaths assess the whole person, exploring the physical, mental, emotional and spiritual aspects of the individual. A number of different modalities are generally used in order to stimulate the body's inherent healing capacity.

Modalities include diet, lifestyle counselling, clinical nutrition, herbal medicine and homeopathy.

I understand, the possible health risks associated with Naturopathic Medicine include but are not limited to; aggravation of pre-existing symptoms during the healing process, allergic reactions, mild gastrointestinal disturbances and headaches in response to supplements or herbs.

I have read and understand the above information. I intend this consent form to cover the entire course of care for my present condition and future condition(s). I understand that I am free to withdraw my consent and to discontinue my Naturopathic care at any time.

Patient/Guardian Print Name: ____

Signed:____ Date:____________________________

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