NOONSA LIFE
CHIROPRACTIC & MASSAGE

PATIENT HISTORY FORM - Naturopathy

For our **confidential** records, please answer the following questions and return to reception when complete.

(Mr, Mrs, Miss, Ms, Dr)
Surname: ______________________ **First Name:** ______________________
DOB: ________/________/________ **Age:** __________
Occupation: ______________________ **Health insurance:** ______________________
Email: ______________________
Home Address: ______________________ **Telephone:** ______________________
______________________ **Marital Status:** ______________________
Number of Children, their names and ages: ______________________

Emergency Contact: (Name)______________________ (Phone)______________________
Medical Doctor: ______________________ (Phone) ______________________
What is the main reason for your visit?
____
____

Please tick if you or a family member (parents, siblings, grandparents) **has/have any of the following:**

You	Family		You	Family	
☐	☐	Arthritis (OA or RA)	☐	☐	High Blood Pressure
☐	☐	Alzheimer's disease	☐	☐	Mental illness/Nervous Disorders
☐	☐	Asthma/Bronchitis	☐	☐	Migraine Headaches
☐	☐	Alcoholism	☐	☐	Skin Disorders (e.g. acne, eczema, psoriasis)
☐	☐	Cancer	☐	☐	Obesity
☐	☐	Diabetes	☐	☐	Thyroid disease (over/under active)
☐	☐	Hay fever/Allergic Rhinitis	☐	☐	Infectious Diseases (HIV/Aids, Hepatitis, STD's, etc)
☐	☐	Heart disease/Stroke	Other: ______________________		

Please list past and current medications (*include full name, dosage, length of treatment, and who prescribed them*):

Prescription medications (*e.g. Oral contraceptive pill, HRT, blood pressure medications etc*):
____
____

Non-Prescription medicines (*e.g. Panadol, anti-histamines, Mylanta/antacids, laxatives etc*):
____
____

Natural Medicines (vitamins*, minerals, herbs, and homoeopathic*):
____
____

Please list any substances to which you are allergic or intolerant:
____
____

Diet

Daily consumption of the following:
☐Water ________cups/day ☐Coffee________cups/day ☐Tea__________cups /day
☐Soft drinks________/day ☐Juice_________cups/day ☐Energy drinks _____/day

Food cravings:
____
____

Food sensitivities:
____
____

Dietary intake yesterday:

Breakfast: ______________________________

Snack: ______________________________

Lunch: ______________________________

Snack: ______________________________

Dinner: ______________________________

Snack: ______________________________

Health and Lifestyle

Time you go to bed: ___________________ Time you wake up: ______________________

Sleep pattern	☐ Deep	☐ Regular	☐ Broken	☐ Insomnia
Current stress levels:	☐ low	☐ medium	☐ high	
Energy levels:	☐ low	☐ medium	☐ high	
Libido:	☐ low	☐ average	☐ high	
Exercise:	☐ daily	☐______/week		

Weight: ____________kg **Height: ________cm**
Cigarettes:_______/day **Alcohol:______/day**

Female Clients Only

Please check the following list and tick any that apply, providing any additional information:

Are you currently pregnant? ☐Yes ☐ No Have you ever been pregnant? ☐Yes ☐ No

☐Breastfeeding	☐ Irregular periods
☐Endometriosis	☐ Menopause
☐PCOS	☐ Miscarriage
☐Candida	☐ Premenstrual symptoms
☐Fibroids	☐ Hot flushes
☐IVF history	☐ Other: ______________________________

Male Clients Only

Please check the following list and tick any that apply, providing any additional information:

☐Erectile dysfunction	☐Mood changes
☐PSA test	☐Prostate hypertrophy
☐Urination at night___________times	☐Other: ______________________________

☐ *I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that in accordance with Noosa Life Chiropractic Cancellation Policy, a cancellation fee may apply if I fail to attend a consultation or give less than 24 hours notice. Your signature confirms that all information you have supplied is true and correct.*

Signed…………………………………………………………………………………………..

Date………………....……………………………