Renewing Harmony

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INITIAL CONSULTATION FORM

Personal Information

Name: _____Sex: _____D.O.B:_____Age: _____

If under 18yrs, name of parent or guardian: _____

Street Address: _____

Phone (H): _____ (M): _____

Email: _____Private Health Fund: _____

Referred by: _____Emergency Contact & Ph Number: _____

Marital Status: _____No. of Children & Age/s: _____

General Practitioner name/ address: _____

Other Health Care Practitioners: _____

Occupation: Current: _____Previous: _____

Health Assessment Questionnaire

Presenting Health Issues / Medical Conditions _____

_____

_____

_____

Which symptoms would you like resolved, in order of priority _____

_____

_____

What prescription medication/s are you taking? Please provide dosage and how long you have been taking it_____

_____

_____

What supplement/s are you taking? Please provide brand and dosage and how long you have been taking it_____

_____

_____

_____

Please list a brief description of your health, including any diagnosis/ conditions/ injuries / major events or traumas, starting from your most current, working back to younger years

Age/Year	Health Condition / Event	Duration	Treatment / Outcome

Please list any illness, diseases or ailments your family members may have or have suffered in the past

Relative	Illness / Disease / Ailment
Mother	
Father	
Siblings	
Grandmother (maternal/paternal)	
Grandfather (maternal/paternal)	
Children	

Please list your main stressors in your life (e.g. work, finances, health, etc.) and rate them out of 10 (10 being the most stressful) _____

_____

_____

What are your energy levels out of 10? (10 being the highest) _____

Please tick one or more of the following in regards to your mood / emotions

Addictive Tendencies		Easily Angered		Manic		Perfectionist	
Agitated		High Achiever		Moody		Poor Concentration	
Anxiety		Hyperactive		Nervousness		Restlessness	
Continual Worry		Impulsive		Obsessive Compulsive		Sadness	
Depression		Lack of Motivation		Panic		Sensitive	

Please tick one or more in regards to your sleep patterns

Insomnia		Breathing through your mouth		Snoring	
Sleeping a lot (more than 8hrs every night)		Unable to remember dreams		Sleep Talking	
Teeth Grinding or Clenching Jaw		Unable to fall asleep before midnight		Involuntary daytime napping	
Feeling tired when waking up		Restless Legs		Great	
Waking up through the night		Vivid Dreams		Fantastic	

Do you have any know allergies? Please list _____

Please tick any of the following that you have health issues with (eg bloating, rash, headaches etc)

Onion		Chocolate		Nuts		Cigarette Smoke	
Garlic		Fish		Gluten		Preservatives	
Eggs		Bread		Citrus		Dairy	
Wine Red or White		Pasta		Chemicals / Perfumes		Tomatoes	

Other: _____

Goals

What are your main treatment goals?

1. _____
2. _____
3. _____

Lifestyle

Do you use or have you in the past used recreational drugs? **Yes/No (Now/Past)**: **Types**: _____

How often do you use pharmaceutical / over the counter drugs? _____

Do you smoke? **Yes/No If yes how many (per day**)? _____ **(Now/Past)**

Do you exercise? **Yes/No If yes how often (per week)?** _____ **Type**: _____

What do you do for relaxation & how often? _____

Have there been any recent changes in your life (eg. work, relationships, house move etc)?

_____

Please provide your fluid intake per day:

Water **(Litres per day)** _____ tap/ bottled/ filtered/ rainwater

Coffee: _____ instant/ espresso/ decaffeinated Milk? (**Y/N)** Type: _____

Fruit juice: _____ Soft drinks/ diet drinks: _____

Black tea: _____ Green tea: _____ Herbal teas: _____

Sports drinks: _____ Sugar added to drinks/ foods: _____

Alcohol? **Yes/No How many drinks per week?** _____ **Type**:_____

Male

Do you suffer from the inability to maintain an erection? **Yes/ No**

Do you have heaviness/ hardness/pain in any of the reproductive areas? **Yes/No**

Are you losing body hair? **Yes/ No**

In regard to your flow of urine, have you noticed a diminished strength of stream? **Yes/ No**

In regard to your flow of urine, do you have difficulty stopping? **Yes/ No**

Female

Please describe your menstrual flow: **absent/ peri-menopausal/ menopausal/ menstrual**

How many days does your flow last? _____ Is the flow: **normal/ heavy/ light**

How often does your flow come? **Every 15-20 days/ 28-29 days/ 30-35 days/ irregular**

Do you suffer from premenstrual tension? **Yes/ No** Do you suffer pain? **Yes/ No**

If so, which symptoms? **Painful breats/ exaggerated responses/ other** _____

Are you taking anything that affects your hormones? **Pill/implanon/marena/HRT/other** _____

If so, is this to control any of the following:

Painful Periods		Irregular Periods		Heavy Periods		Acne	

Other

_____

How many times have you been pregnant? _____

Please tick &/or comment on any symptoms which you suffer or have suffered from regularly

Symptom	Yes	Comments
Bloating (related to digestion)		
Heartburn		
Reflux		
Excessive burping		
Stomach pain		
Stool – constipation (miss days or straining)		

Stool – diarrhoea/loose stools		
Stool – appearance other than dark brown		
Flatulence - excessive		
Nausea		
Thrush		
Bladder problems – urinary tract infection		
Waking at night to urinate (if yes how often?)		
Hemorrhoids/varicose veins/spider veins		
High blood pressure		
Low blood pressure		
Cold hands and feet		
High cholesterol		
Anaemia		
Feel fluidy or swollen		
Dizziness		
Migraines		
Headaches		
Asthma		
Hayfever / sinus problems		
Respiratory problems		
Viruses – e.g. herpes/chicken pox etc.		
Colds/flus/coughs more than twice per year		
Skin–acne/eczema/psoriasis /tinea etc		
Infertility		
Low libido		
Hair loss		
Forgetful/vague		
Back pain		
Muscle cramps or aches		

Consent

I hereby agree and understand that the treatment/advice given will include one or more of the following; dietary prescription, lifestyle prescription, nutritional/herbal supplements and screening tests, which I knowingly and willingly consent to undergo of my own free will. At any time I may reject any treatment or advice without prejudice from the practitioner. I understand that nutritional/herbal supplements are prescribed in a therapeutic fashion and if circumstances change (e.g. pregnancy, cessation/commencement of pharmaceutical drugs etc) from what was presented to the practitioner, I will notify the practitioner immediately, so treatment/advice can alter accordingly if required. I understand that contact details may be used to enable correspondence via email.

Signature_____ Date_____