INITIAL QUESTIONNAIRE

Personal Information

Name:

Date of Birth: Age: Contact Number:

Address:

Email:

Family Details (partner / children):

Current Living Situation (alone / flatmate / partner / parents):

Occupation: Height: Weight:

GP Name and Clinic:

Date and Reason of Last Visit to GP:

Have you seen a Naturopath or Nutritionist before? YES NO

Details:

Date & reason for the last visit:

What would you like to achieve from your appointment?

Health Information and Family History

Medications - Please list all medications

Name	Dose	Length of Use	Reason for Taking

Supplements - Please list all supplements:

Name	Dose	Length of Use	Reason for Taking

Surgeries/Accidents please list all surgeries and accidents and dates:

Childhood Illnesses please list all illnesses and dates:

Adolescent Illnesses please list all illnesses and dates:

Adult Illnesses please list all illnesses and dates:

Allergies:

Sleep: What time do you go to bed? What time do you wake up?

Blood Sugar: Do you get irritable if too long in between meals?

Shaky? Headaches?

Consent and Authority

1. I consent to treatment for which may involve physical examination. I understand that it is not a substitute for medical examination, diagnosis or treatment and is to be used in the conjunction with medical treatment.
2. I understand my practitioner relies on the information I have given them and to the best of knowledge and ability I have and will provide accurate health information and if there are any changes to this information, I will advise my practitioner.
3. I understand that the practitioner abides by the Code of Professional Ethics of the Complementary Medicine Association (*a copy is available by request*).
4. I understand that the practitioner will recommend 'practitioner only' products and will provide relevant information regarding dosage and suitability of the products. I understand it is not recommended to suggest these products to family and friends without seeking the practitioner's advice first.
5. I give permission to Happy and Healthy with Jen to collect and use and disclose my personal information. I understand that I may withdraw my consent as to the use and disclosure of my personal information except when legal obligations must be met. I am aware that I am entitled to access my own health records as outlined above.
6. I understand that all personal details and information will be treated with complete professional confidentiality.
7. I give permission to Happy and Healthy with Jen to place me in the practice reminder system if appropriate for my care.

Signed: _____ Date: _____

Print Name: _____

Please mark conditions you may have or had in the past and if there is any history for your parents or family.

Illness	You	Father	Mother	Family
Headaches / Migraines				
UTIs / Thrush				
Asthma				
Eczema / Psoriasis				
Arthritis – Rheumatoid / Osteo				
Thyroid Issues				
Hepatitis / Liver problems				
Ulcers				
Constipation / Diarrhoea				
Heart Attack				
Stroke				
Heart Disease				
Diabetes				
Anaemia				
Emphysema				
Epilepsy				
Cancer				
Multiple Sclerosis				
Depression / Anxiety				
Alcoholism / Illicit Drug Use				
Other:				

Please mark it you have experienced any of the following in the past 12 months.

IMMUNE		GASTROINTESTINAL THYROID			
Colds / Influenza		Belching / Heartburn / Reflux		Fatigue / Tiredness	
Allergies /Hay Fever		Bloating / Flatulence		Fatigue During Exercise	
Ear Infection		Frequent Nausea		Poor Energy on Waking Weakness	
Thrush / Athletes Foot		Stomach Pain / Cramps		Dry Skin	
Cold Sores / Herpes		Loose Stools / Diarrhea		Dry, Brittle Hair	
Glandular Fever / Epstein Barr		Hard / Dry stools		Hair Loss	
Auto Immune Conditon		Constipation		Weight Gain	
Tonsillitis		Gastrointestinal Infection		Sensitive to Cold	
Sinusitis		Food Poisoning		Cold Hands and Feet	
Slow Recovery After Illness		Blood in the Stools			
Used Antibiotics		Mucous in the Stools			
		Undigested Food in the Stool		URINARY	
ADRENALS		Parasites		Kidney / Urinary Tract Infection	
Fatigue / Tiredness		Candida		Frequent Urination	
Trouble Getting to Sleep		NERVOUS SYSTEM		Getting Up at Night to Urinate	
Waking During the Night		Frequent Sad Feelings		Leakage with Cough / Exertion	
If Wake, Difficult to Get Back to Sleep		Depression		Pain on Urination	
Craving Sugar		Feelings of Anxiety / Panic		Blood in Urine	
Craving Salty Foods		Apathetic		Interrupted Urine Flow	
Craving Starch		Loss of Interest / Enjoyment in Life			
Craving Alcohol		Can't Switch Off Mentally		MUSCULOSKELETAL	
Nightmares		Feeling Stressed		Body Aches / Pains	
Wake Unrefreshed		Dwell on Stressful Situations		Joint Pain	
Low Libido / Sex Drive		Difficulty Concentrating		Joint Swelling	
		Change in Appetite		Joint Stiffness	
CARDIOVASCULAR		Thoughts About Suicide		Headaches	
Chest Pains / Angina		Comfort Eat or Drink			
Palpitations		Racing Thoughts		SKIN	
Breathlessness		Mood Swings		Boils	
Dizziness / Vertigo		Irritability		Psoriasis / Eczema	
Ankle Swelling		Winter Blues		Poor Wound Healing	
Leg Pain with Exertion		Obsessive Thoughts / Behaviors			

Reproductive History

	Current	Past		Current	Past
Breast Cancer			Endometriosis		
Breast Cysts / Lumps			Herpes		
Ovarian Cysts			Sexually Transmitted Diseases		
Fibroids			Abnormal Pap Smear		

Use of Contraception / Hormones

	Current	Past
Used Combination Oral Contraceptive Pill (Oestrogen / Progestin)		
Used Mini-Pill (Progestin Only)		
Used Depo-Provera		
Used Contraceptive Implant		
IUD		
Merina Coil		
Bio-Identical Hormones eg Progesterone, DHEAS, Oestrogen		

Current Menstrual Symptoms

Symptom	Mild	Moderate	Severe	Number of days
Menstrual Pain / Cramping				
Bloating / Fluid Retention				
Breast Tenderness				
PMS / PMT				
Fatigue				
Food Cravings				
Acne / Pimples				
Headaches / Migraines				
Spotting Before Period Starts				
Clots in Menstrual Blood				
Lower Back Pain				
Pain / Cramping Between Periods				

What is your current menstrual cycle length? _____ days
(for example: 26/27/28/30 etc)

What is the shortest cycle experienced in the last 6 months? _____ days

What is the longest cycle experienced in the last 6 months? _____ days

How many days do you bleed for? _____ days

Is your menstrual bleed (please circle) Light / Medium / Heavy

Do you use (please circle) Menstrual Underwear / Pads (Organic?) / Tampons (Organic?)