Confidential Client Information Sheet

Abundant Life & Health
Parramatta Naturopathic Clinic

Date _____ Who Recommended us? ……

Name: …….. Date of birth:……... Country of Birth: ……Sex: M/F

Address: ……. Tel Home:……. Work: …….. Mobile …….....

Suburb ……**postcode**...……. **E-mail***:…….....Height ……..Weight ……...

Next of Kin: ……Relationship: …… Contact phone: ..……..

Current health state: Main reason for this visit …….....

……

Detail **ALL** your symptoms: .....

.....

When did the symptoms first appear? …… Are they getting WORSE/BETTER? **Circle one**.

Any time of day that they are worse or better? …….....Worse/Better. **(Please circle one).**

Anything make it worse/better? …….....Worse/Better **(please circle one)**

Any other health issue causing concern (secondary complaints)? .....…….....

…….....

……What is your **Blood Type** …….....

Do you smoke or use social drugs (**type & quantity/day**)…….....

Do you drink Alcohol? If so **what type and daily quantity**?: …….....

What type of work do you do **(describe fully**)?……..……..

Do you handle or have you *ever* handled, Chemicals, if so what type? ……..... How long for? ….....

How do you feel about your work? ……...

Are you currently being treated by a Doctor? …… Doctor's name: ……

Reason for this treatment? …….

List *all* Medication being taken (*include* contraceptive pill and vitamins/herbs)? ……...

……

Have you **ever** been hospitalised or had an operation (details including year)? ……..

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Have you been **recommended** to have an **operation** if so what and why? ……

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Married/Widowed/Divorced/Single/ Relationship (**Please Circle One**). How do you feel about this relationship? …….....

Any Children, how many and ages? ……

Do you get any regular exercise? …… ……... …… Frequency? …….....

Family Health list *serious* conditions and include age at death if applicable for all *close* family members.

……

Do you have any allergies (list everything you **know** you are allergic to): .....

…….....

Please describe your <u>Typical</u> Diet:

What sorts of foods do you *typically* have for:

Breakfast? .....

Lunch? .....

Dinner? .....

Snacks (what and how often)? .....

Do you CRAVE anything? .....

Soft drinks: …… Tea (what type & how many per day): …….....

Coffee, Real or Instant, state which? ……..... How many? .....

How much water do you drink per day: ……..... Filtered or Tap? (**circle one**).

Sleep: Do you get to sleep easily? …… Do you wake frequently: ……..… If so, why? .....

How do you feel first thing in Morning : ……. How long after getting up before you feel OK? ……..

Do you have dreams/nightmare's (**Circle which**)? …… Are they in colour or black & White (**circle one**)

Do you snore? …… What are your energy Levels in general? …….....

Mental/Emotional Health State:

Would you say you were an anxious worrying sort of person? Yes/No Have you ever had a Panic Attack? Yes/No

Are you now depressed? Yes/No Have you ever been clinically (Dr. diagnosed) depressed? Yes/No.

Cardiovascular Health:

Do you have a heart condition? Yes/No. If so what?.....

Do you have High Blood Pressure? Yes/No.

Do you have any diagnosed vein or artery condition if so what? .....

Do you have Haemorrhoids? Yes/No. Do you have Varicose Veins? Yes/No. (**please circle one**).

Ear/Nose and Throat:

Do you have any sinus or Nose problems? Describe. .....

Do you get Hay Fever? Yes/No? If so is it Spring/Autumn/Any time? (**Circle one**).

Do you have ear problems Yes/No? Describe: .....

Tinnitus? Yes/No.

Throat problems Yes/No? What type and how frequently? .....

Gastro Intestinal tract:

Do you get Reflux? Yes/No. how often ..... Heartburn? Yes/No. how often? .....

Do you get bloating after food? Yes/No. Do you have problems with gas? Yes/No

Do you get Stomach pain? Yes/No. How often? ..... Abdominal pain? Yes/No. How often? .....

Are you ever Constipated (passing stool difficult)? Yes/No. Is there ever blood in the stool? Yes/No

Is there ever undigested food in your stool? Yes/No

How often do you have a bowel movement? ..... Is the stool well-formed/pebbly/loose/liquid

Urinary/Kidneys:

Dose your urine burn? …… Colour: .....…… Have you ever been told you have gout? Yes/No

Is there ever blood in urine? Yes/No. Do you have difficulty controlling your bladder? Yes/No.

Do you ever experience pain in the kidney area? Yes/No. Have you ever had Kidney stones? Yes/No.

MEN:

Do you have difficulty starting to urinate: Yes/No. Is the stream weak? Yes/No. Dribbling after urinating? Yes/No

Do you wake frequently to urinate? Yes No. Does it often feel as if you have not completely emptied bladder? Yes/No.

Immune System:

Do catch whatever's going around? Yes/No How often do you get the Flu/Colds? .....

Do you recover quickly? Yes/No. Or do infections take forever to go away? .....

How many times have you had Antibiotics during the last ten years? .....

Have you EVER had three or more courses straight after each other? …….

Respiratory

Do you have Asthma? Yes/No. Do you use a Puffer, if so what type? .....

Do you have any breathing or other lung issues? ……

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WOMEN:

How long is your Monthly Cycle?) ..... Days. Do you experience pain? Yes/No What type? .....

Do you know if you ovulate and when? .....

Do you get emotional the week before your periods? Yes/No. If so is it Anger/Teary/Wanting to be alone?

Are your period's heavy? Yes/No. Is there Clotting? Yes/No Is the flow dark coloured or bright red? .....

Have you had a Hysterectomy? Yes/No. If so – Uterus only or also Ovaries? .....……..

Are You Pregnant? …… How far on: ……..... Are you trying to Conceive? ...……

Skin issues?

Dermatitis? Yes /No. Where? .....Acne? Yes/No. Where? .....

Eczema? Yes/No. Where ..... Psoriasis? Yes/No. Where? .....

Other? .....

How long have you had this problem? ..... Anything make it worse? Yes/No. What? .....

Muscular/Skeletal:

Do you have Muscle pain? Yes/No. Where? .....

Do you have joint pain? Yes/No. Where? .....

Have you been diagnosed with any Inflammatory condition of the muscles or joints? Yes/No.

What was the diagnosis? .....

Pain levels (1 to 10 with 1 being no pain) 1.....10.

Does ***anything*** make it better? Yes/No. What?. .....

Does ***anything*** make it ***worse***? Yes/No. What? .....

Do you get treatment regularly from: Massage Therapist/Chiropractor/Osteopath (circle any that apply)?

Exercise:

Do you get any exercise? Yes/No. What type? ..... Frequency? .....

Comments:

Client Signature: .....

PRACTITIONER USE ONLY **Practitioner: .....**

Appearance:
.....

BP **:** Pulse Glands:……..

Skin ……..... Nails …….....

Hair ……..... Tongue …….....

Iridology: ……..

……

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Tests done or recommended:

. …….....

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Notes:. ……...

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Prescription/Recommendations: ……...

…….. …….

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Dietary recommendations:

To do at next visit: .....

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Follow up date & time: ……

Entered into Clinic Management System. Yes/No

Alkaline Foods list given? Yes No

First appointment letter sent? Yes/No