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CONFIDENTIAL PATIENT INFORMATION

All information discussed will remain confidential

1. **Please *email* back the completed form *prior* to your appointment.**
2. **If the appointment is for two people ie mum and child, please complete a separate form each.**
3. **The more information you can include the better as the time in your appointment can be more productive, however if you prefer to complete only the address section and verbally discuss the balance within the appointment that is fine also.**
4. **If you are able to cut and paste a photo into this doco that is helpful.**

Appointment Date:

Parent's Name: **Date of birth:**

Child's name: **Date of birth:** **Age:**

Child's name: **Date of birth:** **Age:**

Consultation is for:

Profession/work (if currently a mum, state this and write work prior to this role):

Address:

Phone: **Mobile:** **Email:**

Private Health Insurance – if yes, which one:

Referral from:

What is the *primary* issue you would like to improve?

How long has this been an issue?

What have you done to date to help resolve this?

Health history of Mother:

Health history of Father:

Health history of client's child/children (if applicable):

Issues Faced

Past physical/emotional issues:
1.
2.
3.
4.

The following is as much for your benefit as mine. Very often clients will forget past symptoms, as they resolve and heal.

Current physical and emotional issues:
1.
2.
3.
4.

Please **delete inapplicable** information and add any additional information:

5. Urination: bed wetting, frequent urination. Going to the toilet during the night? no of times?
6. Stools: constipated, hard or pebbly, diarrhea, alternates between constipation and diarrhea
7. Headaches: front, back, side, inside. Frequency?

8. Eyes: red, blurry, 'floaters', sore, itchy, dry
9. Skin: dry, red, blotchy, lumpy, pimples, eczema
10. Circulation: Cold hands, Cold feet Muscle cramps,
11. Appetite: Poor appetite for breakfast Poor appetite generally Excess appetite
12. Digestion: Bloated belly, Nausea, Stomach pain, Indigestion, Heartburn, Low blood sugar
13. Breath: Bad breath, Shortness of breath, Asthma
14. Sleep: Go to Bed at wake up no. of hours sleep
    a. Difficulty falling asleep, Waking in the night – how often
15. Energy:
    a. Tired upon waking, Tired at (time), Less/more tired after eating
    b. Legs tired walking up stairs, tired unexpectedly, easily fatigued
16. Exercise – type and frequency:
17. High or Low blood pressure, Dizziness, Shaky feeling hands/limbs, Nose Bleeds, Bruise easily
18. Teeth - amalgam fillings? Root canals? Any major problems?
19. Vaccinations?
20. Anxiety, Poor memory, Foggy thinking
21. Basal temperature: optional – if you're able please take your temperature upon waking.
22. Any other ailments:
23. **Women**:

Menopause: Age started: Age finished: Night sweats, afternoon sweats, hot flushes?
Menstruation: Length of bleed: Length of cycle: Discomfort? PMT?

a. Flow – light, heavy, pale/watery, dark, clotting, flooding, spotting

What other practitioners are you currently seeing?

Supplements?

Any foods you prefer not to eat?

Food cravings?

Foods generally consumed

(the more info the better.)

B'fast:

Snacks or m'tea:

Lunch:

Snacks or a'tea:

Dinner:

Dessert:

Drinks – ave quantity per week - coffee alcohol soft drinks packaged juice

Water – approx per day:

Foods consumed occasionally for these meals:

B'fast:

Snacks or m'tea/a'tea:

Lunch:

Dinner:

Dessert:

Any further information you would like to share: