PERTH HEALTH & FERTILITY

Health Questionnaire

Name:_____ Date: _____

Address:_____

Email: _____ Referred by: _____

Tel: H _____ W _____ M _____

D.O.B. _____ Age: _____ Occupation: _____

What is your main reason for seeing a naturopath?

_____

_____

_____

Food allergies:_____

Drug allergies: _____

Other allergies: _____

Pre existing medical conditions _____

_____

Are there any diseases that run in your family?

_____

Current Medication (and duration of use): _____

_____

Anything to note from last blood tests: _____

_____

In the last 12 months have you had any of the following medications? (please circle)

Laxatives Anti acids Sleeping tablets Anti depressants Antibiotics Anti inflammatories

Current vitamins, minerals, herbs: _____

_____

Please rate out of 10 (10 is the highest):

Energy levels: ____ Stress levels: ____ Emotional wellbeing: ____

How many times do you poo? In a day:_____ In a week: _____

Please mark the appropriate column:

Have you ever day?		Never	In the past	On occasion	Often	Further Information
Digestion	Bloating after meals					
	Excessive flatulence					
	Constipation					
	Diarrhoea					
	Heart burn/ reflux					
	Nausea					
Respiratory	Asthma					
	Hay fever					
	Colds/coughs in winter					
	Sinus infections					
	Ear infections					
	Sore throat					
Cardio-vascular	High Blood Pressure					
	Varicose veins					
	Cold hands and feet					
	Raised cholesterol					
Reproductive Female	PMS(anger, sadness, anxiety)					
	Menopausal symptoms					
	Erratic Cycle					
	PCOS					
	Endometriosis					
	Heavy periods					
	Painful periods					
	Breast tenderness					
	Fluid retention					
	Ovulation pain					
	Abnormal pap smears					
Male	Erectile difficulties					
Skin	Eczema					
	Psoriasis					
	Dryness					
	Bumps-on top of arms/ legs					
	Itchiness					
Nervous system	Anxiety					
	Depression					
	Heart palpitations					
	Low mood/flatness					
	Mood swings					
Musculo-Skeletal system	Joint/ muscle pain					
	Leg cramps					
	Headaches					
	Migraines					
Sleep	Difficultly falling asleep					
	Waking in the night					
	Waking unrefreshed					

Do you skip meals? Yes/No (please circle)

Please provide examples of each meal:

Breakfast: _____

Morning tea: _____

Lunch: _____

Afternoon tea: _____

Dinner: _____

Dessert: _____

Cravings: _____

Aversion:_____

Appetite: _____

Water (per day): _____ Tea (per day): _____ sugar: _____ milk: y/n

Coffee (per day) _____ sugar: _____ milk: y/n Alcohol(per week):____

Soft drink: (per week): _____ Juice (per week): _____

Other: _____

Please bring your questionnaire to your first appointment.

Would you like to go on our newsletter emailing list to keep up to date on our information seminars, recipes and clinic news? Y/N (email addresses are kept confidential and used for no other purpose).

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