**Health Questionnaire**

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| **Date** |  | |
| **Full Name** |  | |
| **Address** |  | |
| **Email** |  | |
| **Referred by** |  | |
| **Telephone** | **H:**  **W:**  **M:** | |
| **DOB** |  | **Age:** |
| **Occupation** |  | |
| **Food Allergies** |  | |
| **Drug Allergies** |  | |
| **Other Allergies** |  | |

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| **What is your main reason for seeing a naturopath?** |
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| **Please list any pre-existing medical conditions?** |
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| **Are there any diseases that run in your family?** |
|  |
| **Current medications and duration of use?** |
|  |
| **Anything to note from last blood tests?** |
|  |
| **Current vitamins, minerals, herbs or supplements you take?** |
|  |
| **How many times do you poo?** |
| In a day:  In a week: |

**Please mark (X) the appropriate column:**

|  |  |  |  |  |  |
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| Have you ever had? | Never | In the past | On Occasion | Often | Further Information |
| **Digestive System** |  |  |  |  |  |
| Bloating after meals |  |  |  |  |  |
| Excessive flatulence |  |  |  |  |  |
| Constipation |  |  |  |  |  |
| Diarrhoea |  |  |  |  |  |
| Heartburn/reflux |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| **Respiratory System** |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Hayfever |  |  |  |  |  |
| Colds/coughs in winter |  |  |  |  |  |
| Sinus infections |  |  |  |  |  |
| Ear infections |  |  |  |  |  |
| Sore throat |  |  |  |  |  |
| **Cardiovascular System** |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |
| Varicose veins |  |  |  |  |  |
| Cold hands and feet |  |  |  |  |  |
| Raised cholesterol |  |  |  |  |  |
| **Female Repro** |  |  |  |  |  |
| PMS (anger, sadness, anxiety) |  |  |  |  |  |
| Menopausal symptoms |  |  |  |  |  |
| Erratic cycle |  |  |  |  |  |
| PCOS |  |  |  |  |  |
| Endometriosis |  |  |  |  |  |
| Heavy periods |  |  |  |  |  |
| Painful periods |  |  |  |  |  |
| Breast tenderness |  |  |  |  |  |
| Fluid retention |  |  |  |  |  |
| Ovulation pain |  |  |  |  |  |
| Abnormal pap smears |  |  |  |  |  |
| **Male Repro** |  |  |  |  |  |
| Erectile difficulties |  |  |  |  |  |
| **Skin** |  |  |  |  |  |
| Eczema |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |
| Dryness |  |  |  |  |  |
| Bumps (on top of arms/legs) |  |  |  |  |  |
| Itchiness |  |  |  |  |  |
| **Nervous System** |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Heart palpitations |  |  |  |  |  |
| Low mood/flatness |  |  |  |  |  |
| Mood swings |  |  |  |  |  |
| **MSK System** |  |  |  |  |  |
| Joint/muscle pain |  |  |  |  |  |
| Leg cramps |  |  |  |  |  |
| Headaches |  |  |  |  |  |
| Migraines |  |  |  |  |  |
| **Sleep** |  |  |  |  |  |
| Trouble falling asleep |  |  |  |  |  |
| Waking in the night |  |  |  |  |  |
| Waking unrefreshed |  |  |  |  |  |

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| **In a few words, please describe your:** | |
| **Energy levels** |  |
| **Stress levels** |  |
| **Emotional Wellbeing** |  |

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| **In the last 12 months, have you used any of the following:** | | | |
| **Laxatives** |  | **Anti-depressants** |  |
| **Antacids** |  | **Antibiotics** |  |
| **Sleeping tablets** |  | **Anti-Inflammatories** |  |

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| **Please provide examples of each meal:** | |
| **Breakfast** |  |
| **Morning tea** |  |
| **Lunch** |  |
| **Afternoon tea** |  |
| **Dinner** |  |
| **Dessert** |  |

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| **Please complete the following:** | | | |
| **Do you skip meals?** |  | | |
| **Cravings** |  | | |
| **Aversions** |  | | |
| **Appetite** |  | | |
| **Water (per day)** |  | | |
| **Tea (per day)** |  | Sugar: | Milk: |
| **Coffee (per day)** |  | Sugar: | Milk: |
| **Alcohol (per week)** |  | | |
| **Soft drink (per week)** |  | | |
| **Juice (per week)** |  | | |
| **Other** |  | | |

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| **Would you like to go on our newsletter emailing list to keep up-to-date on our seminars, recipes and clinic news?** |
| **YES or NO:** |

Please email this questionnaire back to us at [admin@phf.healthcare](mailto:admin@phf.healthcare) before your appointment. Thank you.