Inspire Early Intervention
Holistic early intervention & wellbeing clinic
60 Moore Rd
Kewarra Beach QLD 4879
Phone: 045 724 8889

New Patient Profile

Title (Mr, Mrs, Ms) | Date of first visit:

First name | Surname

Home address | Suburb | Postcode

Email address

Phone (home/work) | Mobile

Skype Address

Date of birth | Marital Status

Number of children & ages

Occupation | Hours/week

Emergency contact | Phone

Your GP | Phone

GP address/clinic

Private health fund

Do you give permission for us to contact your GP if necessary? ◯ Yes ◯ No

Do you give permission for us to contact your GP if necessary? ◯ Yes ◯ No

How did you hear about us?

- ☐ Advertising/Radio
- ☐ Brochure/Flyer
- ☐ Referred by: (Please name friend/GP/etc)
- ☐ Other (Please specify)
- ☐ Drive/walk past
- ☐ Internet/Yellow Pages/Seminar

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What are your main health concerns? Please prioritise for us.

1.

2.

3.

4.

5.

6.

What are your wellness & health goals/reason for this visit?

Could you be pregnant? ◯ Yes ◯ No

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Do you have any allergies? ◯ Yes ◯ No

Please list:

Medications/vitamins/supplements:

Environmental:

Food:

- ☐ Gluten
- ☐ Dairy
- ☐ Sulphur (e.g. eggs, garlic, cabbage)
- ☐ Sulphites (e.g. red wine)
- ☐ Soy

Further detail on type of reaction:

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List any Pharmaceutical medications you are currently taking

Medication	Daily Dose	How long have you been taking this medication?

List any Nutritional/vitamin/herbal supplements you are currently taking

Supplement	Daily Dose	How long have you been taking this medication?

Health Systems Check (Tick if you experience any of the following symptoms)

Head

- ☐ headaches
- ☐ migraine
- ☐ dizziness
- ☐ fainting

Eyes

- ☐ eyestrain
- ☐ light sensitivity
- ☐ blurred vision
- ☐ watering
- ☐ red eye
- ☐ painful eye

Skin, hair, scalp, nails

- ☐ acne
- ☐ eczema
- ☐ psoriasis
- ☐ hair loss
- ☐ dandruff
- ☐ excess sweating
- ☐ itching
- ☐ redness

Ear, nose, and throat

- ☐ deafness
- ☐ ear noises
- ☐ wax, ear aches
- ☐ sinusitis
- ☐ loss of sense of smell
- ☐ blocked nose
- ☐ frequent colds
- ☐ hayfever
- ☐ allergies
- ☐ sneezing
- ☐ swollen glands
- ☐ nose bleeds

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Mouth, teeth, & gums

- ☐ toothache
- ☐ lost or loose teeth
- ☐ abscesses
- ☐ ulcers
- ☐ mercury fillings
- ☐ bleeding gums
- ☐ grinding teeth
- ☐ taste change

Neck, shoulders, & arms

- ☐ aching
- ☐ tension
- ☐ arm pain
- ☐ tingling
- ☐ cold hands &feet
- ☐ joint pains
- ☐ numbness

Chest

- ☐ pains
- ☐ tightness
- ☐ breathing difficulty
- ☐ coughs
- ☐ wheezing
- ☐ palpitations

Digestive system

- ☐ acidity
- ☐ burning
- ☐ bleeding
- ☐ indigestion
- ☐ nausea
- ☐ sugar cravings
- ☐ loss of taste
- ☐ finger nails chip or peel easily
- ☐ sweat has a strong odour
- ☐ bad breath
- ☐ vomiting
- ☐ bloating
- ☐ constipation
- ☐ diarrhoea
- ☐ haemorrhoids
- ☐ fissures
- ☐ change of stool colour
- ☐ flatulence
- ☐ excess belching

Urinary system

- ☐ thirst
- ☐ frequent going to toilet, day or night
- ☐ burning
- ☐ infections
- ☐ restricted flow
- ☐ change in urine colour or smell
- ☐ blood in urine

Nervous system

- ☐ weakness
- ☐ poor coordination
- ☐ loss of balance
- ☐ memory loss
- ☐ difficulty concentration
- ☐ numbness
- ☐ coldness

Emotional Health

- ☐ depression
- ☐ anxiety
- ☐ restlessness
- ☐ excess worry
- ☐ nightmares
- ☐ insomnia
- ☐ mood swings

Female system

- ☐ menstrual irregularities
- ☐ cramps
- ☐ PMT
- ☐ menopause
- ☐ hot flushes
- ☐ loss of libido
- ☐ discharges
- ☐ infections
- ☐ infertility
- ☐ breast lumps
- ☐ breast tenderness

Male system

- ☐ erection concerns
- ☐ lower back pain
- ☐ sciatica
- ☐ joint pains
- ☐ prostate problems
- ☐ waking in night to urinate
- ☐ change in urine stream – stopping/starting

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General Medical History

Details of operations	What?	When/date?	Any complications?

Details of major illnesses	What?	When/date?

Details of childhood illnesses	What?	Approx. age?

Have you taken antibiotics in the past? If so, when was the last time and what did you take them for?

Have you been prescribed and taken oral flagyl, tetracycline, antacids, antifungals or steroids?

Please elaborate where required:

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Family History

1. Place a tick ☑ in the appropriate place if a family member suffers from this problem.

2. Place a cross ☒ in the appropriate place if a family member has passed away from this illness. If you know their age at the time they passed away please include this information.

	Condition	Mother		Father		Siblings		Maternal G'mother		Maternal G'father		Paternal G'mother		Paternal G'father	
1.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Section 1 - Diet

Tell us about your diet. What do you eat on a daily basis?

Dietary evaluation of a typical day		
On rising	**Breakfast**	**mid morning**

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Dietary evaluation of a typical day		
Lunch	**Mid afternoon**	**Dinner**
Dessert	**Snack/supper**	**Bedtime**

1a. How much water do you drink a day?

1b. How many cups of tea/coffee do you drink in a day. Do you drink energy drinks?

1c. Do you every drink soft drink? If so what and how many bottles/cans per week.

1d. How much alcohol do you drink each day? What do you drink and how many days a week do you drink?

1e. Is there anything you just don't eat ever? If so what is it and why don't you eat it.

1f. What foods make you feel good?

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Section 2 - Sleep

2a. Do you have any issues sleeping?

2b. If you do, is it staying asleep or falling asleep that's the issue. How long has this been going on?

2c. Do you have difficulty waking up?

Please detail any other issues you are having:

Section 3 - Energy

What are your energy levels like? If 0 is no energy and 10 is the best what would you rate your energy on average each day?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Is your energy consistent? Ie: does your energy fluctuate during the day or is it consistent through the day. If it does fluctuate what is your best time of the day and what is the worst?

Section 4 - Weight

4a. Are you happy with your current weight?

4b. If not do you want to gain/lose weight?

4c. Do you have a history of eating disorders? Please detail.

4d. What is your ideal weight?

4e. How long have you had weight issues?

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Section 5 - Gut issues

5a. Do you suffer from nausea? ◯ Yes ◯ No

5b. If so when, how often a week?

5c. is there anything that you think brings it on?

5d. Do you suffer from pain in the stomach/bowel area? ◯ Yes ◯ No

5e. Do you suffer from vomiting? ◯ Yes ◯ No

5f. Do you suffer from burping? ◯ Yes ◯ No

5g. Do you suffer from wind? ◯ Yes ◯ No

5h. Do you suffer from bloating? ◯ Yes ◯ No

5i. If you eat fatty food do you feel sick/queasy? ◯ Yes ◯ No

Please details any issues you have had with digestion in the past:

Section 6 - Bowels

6a. How often do you go to the toilet to pass a stool on a daily basis?

6b. Do you every miss a day ie: have constipation? If so how many days would you skip?

6c. Do the stools float or sink?

6d. What colour are they? Light brown, mid brown, dark brown, yellowish, greenish?

6e. Is there any blood / mucous in the stool?

6f. Do you suffer from constipation/diarrhea or both?

6g. Do you use laxatives? ◯ Yes ◯ No

Please detail any issues you have had with your bowels in the past:

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Section 7 - Immune system / respiratory system

7a. How many colds or flu do you get a year?

7b. How long does it normally take you to recover?

7c. Have you every smoked? Or do you smoke? Now? How many do you smoke a day.

7d. Have you every taken recreational drugs? If so what? How often, and do you still take them now?

7e. Do you every suffered swollen glands, hayfever, sinus, post nasal drip (ie: feel like something is always dripping down the back of your throat)

7f. Have you ever had asthma? ◯ Yes ◯ No

7g. Do you every get short of breath? ◯ Yes ◯ No

7h. Do you get nose bleeds ◯ Yes ◯ No

7i. Do you ever get a cough? ◯ Yes ◯ No

Please detail any history:

Section 8 - Kidneys

8a. Do you get thirsty a lot? ◯ Yes ◯ No

8b. Do you have to get up through the night to go to the toilet to urinate? If so how many times?

8c. Have you had any issues with your bladder?

8d. Has your urination changed at any time? Do you get urgency? Do you urinate a lot?

8e. Have you ever seen blood in your urine? ◯ Yes ◯ No

8g. Do you every see blood in the urine? ◯ Yes ◯ No

8h. Have you had recurrent cystitis or urinary tract infections? ◯ Yes ◯ No

Please detail any issues you've had in the past:

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Section 9 - Female Reproductive System

9a. At what age did you get your period?

9b. Are you still menstruating? If not at what age did you go through menopause?

9c. If you are still getting your period, is your cycle regular ie: does it come every 28 days. If not please detail

9d. How many days do you bleed?

9e. What is the blood flow like? Heavy / light?

9f. Do you get any clots in the blood flow?

9g. Do you get any PMS symptoms (ie: sore breasts, mood changes, pain, anxiety, cramps). Please detail.

9h. Are your pap smears up to date? When was your last one? Have they all been clear?

9i. Have you ever had wart viruses/infections?

9j. Have you ever had recurring thrush?

9k. What is your contraceptive method?

9l. Have you had any pregnancies? If so how many?

9m. Have you had any issues trying to conceive?

Please detail any reproductive health issues:

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Section 10 - Male Reproductive System

10a. Have you had any issues with sexual dysfunction?

10b. Have you had any issues with infections?

10c. Have you had any issues with conceiving?

Please detail any previous health issues:

Section 11 - Cardiovascular system/circulation

11a. Have you had any issues with your heart?

11b. Have you had any chest pain/ palpitations?

11c. Do you suffer from cold hands/fee

11d. Do you or anyone in your family suffer from varicose veins.

11e. Do you get dizzy on standing?

11f. you're your blood pressure usually high or low?

Section 12 - Musculoskeletal system

12a. Do you get cramps in your legs/feet regularly ◯ Yes ◯ No

12b. Do you get back pain, stiffness? ◯ Yes ◯ No

12c. Do you ever get tingling, numbness, pins and needles? ◯ Yes ◯ No

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Section 13 - Skin

13a. Do you have any issues with your skin – dry, eczema, psoriasis, warts, how do you heal?)

Section 14 - Exercise

How much exercise do you do a week. Please list and time you spend doing it.

Section 15 - Relax

What do you like to do to relax?

Section 16 - Anxiety

16a. Do you suffer from anxiety/panic attacks? ◯ Yes ◯ No

16b. On a scale of 0 (no anxiety) and 10 (panic attack) what is your anxiety level?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

16c. What symptoms do you get ie: sweating, shaking, fear of going outside, dizziness, vomiting, blurred vision?

16d. How long has this been going on?

16e. Was there something that started it?

16f. Is there anything that makes it better?

16g. is there anything that makes it worse?

Please detail:

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Section 17 - Depression

17a. Rate your mood. (if 0 is bad depression, whereby you cannot get out of bed and you just want to hide from the world and 10 is feeling extremely happy , how would you rate your mood?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

17b. Do you get foggy head? ○ Yes ○ No

17d. Do you get a thick, cannot think, blocked head? ○ Yes ○ No

17e. How long has the depression been going on?

17f. Was there anything that started it?

17g. Have you ever been on medication in the past for depression? If so what and when?

17h. What are the significant stressors in your life?

17i. Before you got sick where there any significant changes? New house? New job? Travel? Death in the family?

Is there anything else you think we should know?

Please list any additional information you feel is relevant below: