

Title (Mr, Mrs, Ms)	<input type="text"/>	Date of first visit:	<input type="text"/>		
First name	<input type="text"/>	Surname	<input type="text"/>		
Home address	<input type="text"/>	Suburb	<input type="text"/>	Postcode	<input type="text"/>
Email address	<input type="text"/>				
Phone (home/work)	<input type="text"/>	Mobile	<input type="text"/>		
Skype Address	<input type="text"/>				
Date of birth	<input type="text"/>	Marital Status	<input type="text"/>		
Number of children & ages	<input type="text"/>				
Occupation	<input type="text"/>	Hours/week	<input type="text"/>		
Emergency contact	<input type="text"/>	Phone	<input type="text"/>		
Your GP	<input type="text"/>	Phone	<input type="text"/>		
GP address/clinic	<input type="text"/>				
Private health fund	<input type="text"/>				

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

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**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

**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

**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:

**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)**

- |   |  |   |
|---|--|---|
| <p><b>Head</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> headaches</li> <li><input type="checkbox"/> migraine</li> <li><input type="checkbox"/> dizziness</li> <li><input type="checkbox"/> fainting</li> </ul> <p><b>Eyes</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> eyestrain</li> <li><input type="checkbox"/> light sensitivity</li> <li><input type="checkbox"/> blurred vision</li> <li><input type="checkbox"/> watering</li> <li><input type="checkbox"/> red eye</li> <li><input type="checkbox"/> painful eye</li> </ul> | <p><b>Skin, hair, scalp, nails</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> acne</li> <li><input type="checkbox"/> eczema</li> <li><input type="checkbox"/> psoriasis</li> <li><input type="checkbox"/> hair loss</li> <li><input type="checkbox"/> dandruff</li> <li><input type="checkbox"/> excess sweating</li> <li><input type="checkbox"/> itching</li> <li><input type="checkbox"/> redness</li> </ul> | <p><b>Ear, nose, and throat</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> deafness</li> <li><input type="checkbox"/> ear noises</li> <li><input type="checkbox"/> wax, ear aches</li> <li><input type="checkbox"/> sinusitis</li> <li><input type="checkbox"/> loss of sense of smell</li> <li><input type="checkbox"/> blocked nose</li> <li><input type="checkbox"/> frequent colds</li> <li><input type="checkbox"/> hayfever</li> <li><input type="checkbox"/> allergies</li> <li><input type="checkbox"/> sneezing</li> <li><input type="checkbox"/> swollen glands</li> <li><input type="checkbox"/> nose bleeds</li> </ul> |
|---|--|---|

## New Patient Profile

### 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

**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:**

**Family History**

- Place a tick  in the appropriate place if a family member suffers from this problem.
- 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	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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

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?



**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?

**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:

**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:

**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:

**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

Please detail:

**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:

