**Confidential Initial Health History - Healthier By Choice**

|  |  |
| --- | --- |
| **Name** : **Phone** : **Email** :Address :  | Who referred you / how did you hear about me? |
| DOB :  Age : Current Weight :Ideal Weight:Height: | Occupation:Hobbies:Children’s names & Ages :Are there any medical concerns with any of your children?  | Who do you live with?Are you Married | Single | Partnered | Divorced | WidowedPartner’s name & age: |
| **Do you currently have a contagious condition / cough / respiratory illness / blood-borne virus?**  | **Do you have a mental illness / issue?** (eg OCD, bipolar, schizophrenia, depression, anxiety, suicidal)  | **Do you have any Addictions** (eg: Sugar / drugs / alcohol / smoking / sex / gambling / gaming) |
| **What are you wanting help with?**  | **Briefly, what is the story/history of your current issue/s?** What is going on in your life right now? What recurring thoughts are occupying your mind most at present? |
| **What are your expected outcomes from your sessions?** | **In order of priority, what are the top three things you want to achieve?****1.** **2.** **3.** |
| **What are your current obstacles to health**? | **What have you tried / done already?** |
| **What Supplements are you taking?** (Include the brand, how long you have taken and what it is are for) |
| **What Medications do you take?** (Include the dose, when started (year), and what they are for. Include medications you take occasionally, and how often you take them in a month. Also include panodol, contraception, antihistamines etc.) |
| **Consent:** I give consent for | yes | no |
| * **Personal information** **to be collected** and stored for booking, and case management purposes. Reception staff will only have access to your information for the purposes of administering appointment and prescription. **Reminders** - I consent to appointment reminders by SMS or email.
 |  |  |
| * **Occasional Newsletters** and information regarding the clinic ( such as location changes and availability) sent to me via email. (We will not spam you.)
 |  |  |
| * **Alternative Theapies:** I acknowledge that this is not mainstream medical care. We use alternative therapies such as Naturopathy, Herbal Medicine, Nutritional supplementation, homeopathic or resonance remedies, bio-energetic testing, and may use a device that measures the body’s quantum information field, for screening and review purposes. We may also use Bicom bioresonance treatment and bowen therapy where indicated as part of a holistic treatment plan. Please notify us if you do not want some of these therapies.
 |  |  |
| **Name** | **Sign** | **Date**  |

**Are there particular dietary principles or philosophies you follow?**

Are you Vegan?How long for?

**Outline your current diet & lifestyle routine:**

|  |  |  |
| --- | --- | --- |
| **Add Times** | **Diet** | **Lifestyle / Daily Routine** |
| MORNING |  |  |
| MID AM |  |  |
| LUNCHTIME |  |  |
| MID PM |  |  |
| EVENING |  |  |
| BEDTIME |  |  |

**Current Health: 10=high 5 = moderate 1 = low 0=nil**

|  |  |  |
| --- | --- | --- |
| **Please rate your:** | *0-10* | **Comments** |
| Energy levels overall |  | Indicate if varies between morning, afternoon andevening |
| Stress levels overall |  |  |
| Level of Anxiety  |  |  |
| Depression  |  |  |
| Irritability / Frustration? |  |  |
| Teariness / Sensitivity? |  |  |
| Low mood |  |  |
| Memory recall |  |  |
| Rate your overall sense of Wellbeing |  |  |
| Rate your **Weight**? |  |  |
| Sugar cravings  |  | High / moderate / low / non-existant |
| Rate your Skin  |  |  |
| Histamine – itching, rashes, hives |  |  |
| Sinus problems (blocked, congested, Post nasal drip) |  |  |
| Ears – Ringing, itching, blocked, infection |  |  |
| **Overall Digestive Function?** |  |  |
| Bloating / distenston |  | Indicate frequency : a few times in a day / daily / every other day / weekly / other |
| Reflux / gastric burning sensation |  |  |
| Gut pain / nausea |  |  |
| **Rate your Bowel function** |  | Indicate : well formed & easy to pass / loose / diarrhoea / lots of wind / mucus / constipated / urgent / other: |
| How often do you have a bowel motion... |  | Frequency : a few times in a day / daily / every other day / weekly / other  |
| Wind / flatulence. Is *it Odorous?*  |  |  |
| Do you have any Haemorrhoids or blood on wiping?  |  |  |
| **SLEEP - Rate your sleep quality overall** |  | (10=go to sleep easily, sleep through the night and wake well rested) |
| Average hours of sleep |  |  |
| How often do you wake at night? |  | What time/s do you wake? Time taken to go back to sleep -  |
| Overnight trips to the loo (number) |  |

**Women’s Health** (As Appropriate)

|  |  |  |
| --- | --- | --- |
| **HORMONES** – overall sense of Hormone Balance? |  | Notes:  |
| Any night sweats? |  |  |
| Libido overall? |  | High / moderate / low / non-existant |
| Menstrual pain |  |  |
| Breast Tenderness |  |  |
| Premenstrual Tension / Mood changes b4 pd |  |  |
| How long was your last cycle (first day of period to day before flow of next period) |  | Cycle length (days) : 21 / 28 / 30 / 40+ 1st day of last period – date *:*  |
| Menopause / Perimenopause? |  | Year it started :  |

|  |
| --- |
| Do you lose bladder control when you sneeze?  |
| When was your last pap smear & what was the result? |
| How many mamograms have you had?  | Bone Denisty Tests?  |
| In Pregnancy did you have any issues? High blood pressure? Diabetes?  |

**Men’s Health** (As appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| Has the strength of the urine stream changed?: |  | Has your ability to develop or maintain an erection changed? |  |
| Are you concerned about your prostate? |  | Are you concerned? |  |

Do you have any body pain or discomfort? Please rate where **1 = low / 10 = high.**

|  |  |  |
| --- | --- | --- |
| Muscle tension / hardness / knots |  |  |
| Body pain |  |  |
| Headaches – frequency, intensity etc. |  |  |
| Neck & Upper Shoulders |  |  |
| Middle Back |  |  |
| Lower Back |  |  |
| Legs |  |  |
| Arms & shoulders |  |  |
| Joints |  |  |
| Legs  |  |  |
| Feet |  |  |
| What exercise are you doing & how much? Rate the intensity MILD/MODERATE/HIGH |

**How is your body feeling?**

*Note areas of discomfort or issue, and rate out of 10, where 10 is strong / severe****. RECORD ANY SCARS ON YOUR BODY.***

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| --- | --- |
|  |  |

**Current & Past Medical:**

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| **Are you currently under medical care?** Doctor / clinic details: When was your last visit and what was it for?  |
| **Are you seeing any other practitioners?** Who and what for? |
| **Outline your Medical History** : What have you been diagnosed with in your life – include year/s and treatment? | **What Medications have you used in the past**? (Include when, how long for and what for? Also include recreational drugs.) |
| **Hosptialisations / Surgery –** How many general anaesthetics have you had? Are there any organs you no longer have (tonsils, appendix, gallbladder …)?  | Do you have a pacemaker?Have you had a transplant*?*  |
| Do you have any implants or prosthetics?  | How many : XraysMRIs CAT scans What for? |

**Health History.** Please indicate which of the following apply to you:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| X |  | X |  | X |  | X |  |
|  | Emotionl Distress |  | Parasites |  | Memory issues |  | Abnormal Pap Smear |
|  | Hayfever |  | History of gastro / Bali belly  |  | Dizziness |  | Anaemia |
|  | Hives / Urticaria  |  | Coeliac Disease |  | Tinnitis / Ringing in the ears |  | Ovarian Problems |
|  | Sinus issues |  | Irritable Bowel |  | Circulation Problems |  | Endometriosis |
|  | Herpes |  | Coronary Artery Disease |  | Cold hands / feet |  | Sexual/physical abuse |
|  | Cold sores |  | Diverticular Disease |  | Parkinson’s Disease |  | Numbness |
|  | Glandular Fever (EBV/CMV) |  | Reflux |  | Dementia/Alzheimer’s |  | Ovarian cysts |
|  | Molluscum |  | Hiatal Hernia |  | Paralysis / parasthesia |  | Fibroids |
|  | Chicken pox |  | Stomach Ulcers |  | Abnormal Heart Valve/s |  | Thrush |
|  | Measles |  | Helicobacter |  | High Blood Pressure |  |  |
|  | Bronchitis |  | Gluten sensitivity |  | Tingling |  | Anxiety |
|  | Pneumonia |  | Dairy Sensitivity |  | Migraines |  | Panic attacks |
|  | Asthma |  | Colon or Rectal Polyps |  | Headaches |  | Depression |
|  | Shortness of breath |  | Gall Stones |  | Eczema |  | OCD |
|  | Chronic cough |  | Skin Tags |  | Psoriasis |  | Autism |
|  | Post Nasal Drip |  | Diabetes |  | High Cholesterol Level |  | Aspergers |
|  | COPD/Chronic Lung Dx |  | Cataracts |  | Cartoid artery obstruction |  | ADD / ADHD |
|  | Tuberculosis |  | Osteoarthritis |  | Blood Clots/DVT |  | Schizophrenia |
|  | Lung problems |  | Reumatoid arthritis |  | Stroke |  | Seizures / Epilepsy |
|  | Sleep Apnoea  |  | Broken Bone/s  |  | Hearing Loss |  | Pre-eclampsia |
|  | Burning tongue |  | Osteopenia  |  | Stroke |  | Post Natal Depression |
|  | Burning skin |  | Osteoporosis |  | Irregular Heart Beats |  | Gestational Diabetes |
|  | Raynauds |  | Fatty Liver |  | Atrial Fibrillation |  | Cesarean |
|  | Wandering joint pain |  | Cirrhosis |  | Heart Failure |  | Stillbirth |
|  | Auto-immune disease |  | Hepatitis |  | IVF treatment |  |  |
|  | AIDS |  | Hemochromatiosis |  | Blighted Ovum |  |  |
|  | PANS / PANDAS |  | Glaucoma |  | Miscarriage/s |  |  |
|  | Cancer |  | Macular Degeneration |  | Grief |  |  |
|  | Mouldy environment |  | Prostate Issues |  | Smoking |  | Trauma  |
|  | Asbestos contact |  | Kidney Disease |  | Parents smoked |  | Narcissistic Parent / sibling |
|  | Mercury amalgums |  | Gout |  | Farming history |  |  |
|  | Strep Thoat |  | Scars - internal |  |
|  | Golden staph |  | Scars - external |
|  | Shingles |  |  |

**VACCINES** – what year/s and how many doses have you had of:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Flu injections – years / #** :   | Pneumonia  | Tetanus | Hepatitis | Yellow feverRabies |
| MMR | Chicken Pox | Whooping cough | Tuberculosis (TB) – this would have left a scar on your shoulder.  |
| **HPV (Giardasil - Cervical Cancer vaccine)**  | **SMALL POX VACCINE (IMPORTANT TO NOTE) *:***  |
| **Other vaccines – include overseas travel:**  |

**CHEMICALS / PESTICIDES / POISONING**

|  |
| --- |
| **Have you ever been poisoned or had any type of concentrated chemical exposure?** EG:Pesticides, broken thermometer, amalgum filling fall out, broken curly light bulb or fluorescent tube, banana plantation or farm spraying exposure, medical treatment issues, hairdresser, nail technitian, car mechanic or other work expsoure/s, lots of air travel? |
| **Do you wear perfume?** How many years?  | **Do you use spray deoderant / hairspray / aerosole fly sprays?** How many years? |

**TEETH & MOUTH**

|  |
| --- |
| **Any issues with you mouth / gums / teeth / tongue / throat / tonsils**? **Number of**: Silver Fillings \_\_\_\_\_ White Fillings \_\_\_\_\_ Implants \_\_\_\_\_ Bridges \_\_\_\_ Missing Teeth \_\_\_\_\_ **Did you have braces, how old were you, how long for?** |

**Your Personal Timeline** : Briefly outline your personal story and timeline: include relationships, home moves, expsures, infections, proceedures, stressful experiences, traumas, mouldy environments, water damaged buildings, mercury / toxin exposure, pesticides, jobs, procedures, and life events. **EMOTIONS** – record any time peak emotions are experienced and suppressed (fears, worries, stressful experiences that were overwhelming, erosive, traumatic, neglectful, abusive etc) and unresolved, they can have an effect on the central nervous system as they are pushed deep within the body where they block function and program you to expect pain or hardhship. These are often are overlooked as significant initiating traumatic events which go on to lead to dysfucntion and disease later in life. These events may include - having parents who were neglectful, fear-inducing, overly judgemental, impossible to please; it may be physical, emotional or sexual abuse, being in an accident, going to hospital alone, being bullied, shamed or deeply embarassed or humiliated publically. If you witnessed a traumatic event, accident or violence - **ANYTHING like this please record these incidents below. Childhood experiences are particularly important to note, whether you remember them or were told about them. This information often holds the key to getting well.**

|  |
| --- |
| **In Utero** – what was your mother doing before and during her pregnancy with you? Was she stressed, traumatised during your pregnancy, were you planned or unexpected, were you adopted? **if your mother’s emotional state during pregnancy is important.**Was she exposed to cigarette smoke, alcohol, pesticides, environmental agents and medications during pregnancy? Did she have pre-eclampsia or gestational diabetes?What is the gap between you and your closest siblings? Was she pregnant again while breastfeeding you? How long were you breastfed?**Please record your emoptional and physical health experiences, infections, vaccines, injuries, medical interventions, operations, medications, circumstances etc – ask your parents about your early life:** |
| **Infancy:**  |  |
| **Teen / Puberty** *:*  |  |
| **Young Adult** : |  |
| **Adult** : |  |
| **Current**  |  |

**Prior to your 18th birthday:**

|  |  |  |
| --- | --- | --- |
|  | **NO = 0** | **YES = 1** |
| 1. Did a parent or other adult in the household **often or very often**… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
 |  |  |
| 1. Did a parent or other adult in the household **often or very often**… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
 |  |  |
| 1. Did an adult or person at least 5 years older than you **ever**… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
 |  |  |
| 1. Did you **often or very often** feel that … No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other?
 |  |  |
| 1. Did you **often or very often** feel that … You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
 |  |  |
| 1. Were your parents ever separated or divorced?
 |  |  |
| 1. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her? &/or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? &/or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
 |  |  |
| 1. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
 |  |  |
| 1. Was a household member depressed or mentally ill, or did a household member attempt suicide?
 |  |  |
| 1. Did a household member go to prison?
 |  |  |
| Total : Now add up your “Yes” answers: ***\_*** This is your ACE Score (Adverse Childhood Experiences) |  |  |

**Do you carry any …?**

|  |  |
| --- | --- |
| **Guilt**  |  |
| **Regret** |  |
| **Shame** |  |
| **Trauma** |  |
| **Hate****Resentment** |  |
| **Grief** |  |
| **Sense of Loss** |  |
| **Loneliness**  |  |
| **Self-loathing** |  |

**Relationships** - Do you have any difficult relationships in your life at present?

**Stress -** What are your main sources of stress?

**Thank you** for completing this questionnaire. If there is anything else you’d like us to know, plaase add it below.

I look forward to working with you.

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