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

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| --- | --- | --- | --- |
| **Name** : **Phone** :  Address :  **Email** : | | | Who referred you / how did you hear about us? |
| 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 / Widowed  Partner’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 brings you in for a session** **today**? **What are you wanting help with?** | | | |
| **Current Medications, dose, when started (year), and what they are for. Include medications you take occasionally, and how often you take them in a month.** | | | |
| **Current Supplements, brand, how long you have taken and what they are for**? | | | |
| **Briefly, what is the story of your current issue/s?** What is going on in your life right now? What recurring thoughts are occupying your mind most at present? | | | |
| **In order of priority, what are the top three things you want to achieve?**  **1.**  **2.**  **3.** | | | |
| **What do you think are your present obstacles to health**? | | | |

**Current Health Overview: 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) |  |

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 | | |

**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 : |

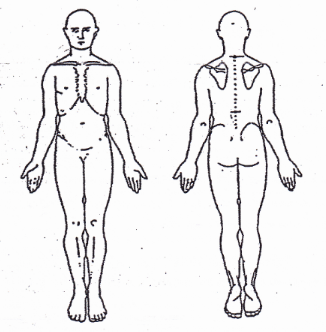
|  |  |
| --- | --- |
| Do you lose bladder control when you sneeze? | |
| When was your last pap smear & what was the result? | |
| How many mamograms have you had? | Bone Denisty Tests? |
| In Pregnancy did you have any issues?  High blood pressure? Diabetes? | |

**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? |  |

**How is your body feeling?**

*Mark any areas of discomfort or issue, and rate out of 10, where 10 is strong / severe.*

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**Current & Past Medical:**

|  |  |
| --- | --- |
| **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 –**

|  |  |
| --- | --- |
| What organs do 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 general anaesthetics have you had? | How many : XraysMRIs CAT scans  What for? |
|  | |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | 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 |  |  |
|  | 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 | Pneumonia | Tetanus | Hepatitis | Yellow fever |
| MMR | Chicken Pox | Whooping cough | Tuberculosis (TB) – this would have left a scar on your shoulder. | |
| **HPV (Giardasil - Cervical Cancer vaccine)** | | | Other: | |

**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 general life events.

|  |  |
| --- | --- |
| **In Utero** – what was your mother doing before and during her pregnancy with you? What exposures to cigarette smoke, alcohol, pesticides, environmental agents and medications did she have?  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?  **Your healt / experience / circumstances 0-7 Infancy -** | |
| **8-16 years old** : | **17-25 years old** : |
| **26-35 years old:** | **36-45 years old:** |
| **46-60 years :** | **60+** |

**Consent**

**Thank you for taking the time to complete this form.** We realise that the form is quite lengthy, but the information provided will help us to get a better picture of any underlying issues affecting your health. In the course of managing our appointment system, we need to have identification details on 1-2 appointment systems, but clinic staff are the only ones with access and it is solely used for clinic appointment scheduling. We will not spam you.

**Consent:**

|  |  |  |
| --- | --- | --- |
| I give consent for | yes | no |
| * my personal information to be collected for the purpose of file keeping, clinical notes, and case management. This includes the practitioners I am seeing, and reception staff in so far as they administer my prescription and book appointments for me. I consent to appointment reminders, to be sent via SMS or email. |  |  |
| * Newsletters and information regarding the clinic including location changes and availability information to be sent to me via email occasionally. (We will not spam you.) |  |  |

**The information I have provided is true and correct**. Should my medication change whild I am taking supplements, I will make an appointment with my practitioner to see if my prescription needs altering.

|  |  |  |
| --- | --- | --- |
| **Name** | **Signed** | **Date** |