**Review Questionnaire**

|  |  |  |
| --- | --- | --- |
| Name :  | Date :  | Appointment # :  |
| What has changed / happened since your last appointment? What are you noticing (be specific)? |  |
| What percentage improvement have you noticed overall? (0=none - 100% vast improvement) |  |
| What percentage have you been on your dietary regime? (0=not - 100% strictly on it) |  |
| What percentage have you been on your supplement regime?(0=not - 100% strictly on it) |  |
| Have you or are you seeing any other practitioners since your last visit? (If so, who & what for?) |  |
| Have you stopped or started any supplements or medications? |  |
| What supplements are you taking presently? |  |
| What is your focus for your next appointment?  |  |
| What is your end goal?  |  |
| What is obstructing or preventing this? |  |
| What has been successful in your treatment so far, what are the positives? |  |
| What has not been successful yet, what are the negatives? |  |
| Have you had any shocks, traumas, injuries or impacts to your body or emotions since your last appointment? |  |
| How are you feeling emotionally compared to your first vist?  |  |

|  |  |
| --- | --- |
| **Medical Update** - are there any medications you have started or stopped, or any medical appointments you have attended?  |  |
| Have you seen any other health care professionals, started or stopped any supplements, herbs or other Natural remedies?  |  |
| How many Neurofen, Panodol, Antibiotics or other over the counter medicines have you used since your last appointment?  |  |

|  |  |
| --- | --- |
| What exercise are you doing & how much?Rate the intensity MILD/MODERATE/HIGH |  |
| **Please rate out of 10 0 = nil / 10 = high** | **0-10** | **Comments** |
| Energy levels  |  |  |
| Stress |  |  |
| Anxiety |  |
| Low Mood |  |
| Irritability |  |
| Teariness |  |
| Frustration |  |
| Sleep quality |  |  |
| Average hours of sleep |  |  |
| Number of times you wake |  | What time/s do you wake? Time taken to go back to sleep -  |
| Mental Clarity / memory |  |  |
| Bowel function overall (well formed & easy to pass / loose / diarrhoea / lots of wind / mucus / constipated / other |  | How often are you having a bowel motion?A number of times a day / daily / every other day / weekly / other : |
| Do you have Haemorrhoids?  |  |
| Bloating |  |
| Wind / flatulence. Is *it Odorous?*  |  |
| Skin  |  |  |
| Night sweats |  |  |
| Sense of Wellbeing |  |  |
| Rate your diet |  |  |
| Weight  |  |  |
| Sugar cravings  |  |  |
| Libido |  |  |
| Headaches / Migraine |  |  |
| **WOMEN** :- | …/10 |  |
| Period pain  |  |  |
| Breast Tenderness |  | *1ST day of last period – date :*  |
| Fluid retention |  |  |
| Flushing / sweating (day / night) |  |  |
| How long was your last cycle (first day of period to day before flow of next period) |  |  |
| PMS (0=none 10= severe) |  |  |

**BODY PAIN / DISCOMFORT** : Please rate where **1 = low / 10 = high.**

|  |  |  |
| --- | --- | --- |
| Muscle tension / hardness / knots |  | **How is your body feeling?***Mark any areas of discomfort or issue.*  |
| Body pain |  |
| Headaches* intensity
 |  |
| Neck & Upper Shoulders |  |
| Lower Back |  |
| Legs |  |
| Arms & shoulders |  |
| Joints |  |
| Legs & feet |  |

|  |
| --- |
| **COVID-19 INFO:** Have you have had the COVID-19 vaccine? If yes, what dates?If no, are you planning to have it?Have you been in close proximity to someone who has taken this vaccine (eg: partner, close contacts)?**PCR TEST:**Have you had a PCR Covid test? How many and what dates?Have you had Covid-19 or tested positive on a PCR test? |

Is there anything else that you would like to add?