**Review Questionnaire**

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| 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? |  | |

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| **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? |  |

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| 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.**

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

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| **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?