Naturopathic Initial Consult Form

To provide you with the best quality care, we ask that you complete the following as accurately and honestly as possible. This form is a PDF document that you can simply type your answers into, print or save as a PDF again and email back to admin@yerongachiropractic.com.au at your earliest convenience. Thank you!

Date of Initial Consultation:

Full Name:

Date of Birth: Age: Sex: Male ☐ Female ☐ Other ☐

Address:

Phone Number:

Email:

(By providing this information I give permission to be contacted by Yeronga Chiropractic & Wellness)

Occupation Hours of work per week:

Marital Status: No. of children:

Emergency Contact:

Relationship to patient: Contact No.:

How did you find out about us?

CURRENT HEALTH CARE TEAM

General Practitioner:

Clinic: Contact No.:

Specialist Physician:

Specialty: Contact No.:

Other Health Care Team Members (e.g. Chiropractor, osteopath, acupuncturist)

Practitioners Name:

Modality: Clinic Name:

YOUR HEALTH GOALS / PRESENTING ISSUES?

Please be specific and in order of importance to you.

1.

2.

3.

What is preventing you from achieving your health goals? *(e.g. time, energy, knowledge, cooking skills, motivation, money etc)*

On a scale of 1-10, how willing are you to make dietary and lifestyle changes?

1 = not prepared to change *10 = I will do anything*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

PERSONAL MEDICAL HISTORY

Country of Birth	
Infanthood	
Childhood illnesses	
Adolescence	
Adulthood	
Surgery	
Traumatic events affecting health	
Recently travelled overseas?	

MEDICATIONS AND SUPPLEMENTS

Please include the medications you take regularly including pharmaceuticals e.g. panadol/nurofen, reflux medication, vitamins, supplements, herbal or homeopathic remedies. Include past medications e.g. anti-depressants, contraceptive pill etc.

Medication and dose	Current or Past	Prescribed or self-prescribed	Frequency	Reason	How long	Were they effective

FAMILY HISTORY

Please include diagnosed mental or physical health conditions from parents, siblings, maternal and parental grandparents e.g. anxiety, depression, heart disease, diabetes, thyroid disease, asthma etc.

Relationship	Condition(s)	Age

GENERAL HEALTH QUESTIONNAIRE

CURRENT HEALTH STATUS

How would you rate your current health?
1 = very poor *10 = perfect health*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

How would you rate your current energy levels?
1 = no energy, can't get out of bed *10 = bursting with energy*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

How would you rate your current stress levels?
1 = no stress *10 = extremely stressed*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Height (cm): Weight (kg):

Last visit to a GP: Reason:

Date of last blood tests:

SLEEP

Average hours of sleep per night:

What time do you go to bed on average?

What time do you wake on average?

Are you a shift worker? ☐ Yes ☐ No

Do you ever experience the following? *(Please tick)*

- ☐ Insomnia
- ☐ Difficulty falling asleep
- ☐ Difficulty waking
- ☐ Difficulty staying asleep
- ☐ Snoring
- ☐ Sleep walking
- ☐ Night sweats
- ☐ Vivid dreams
- ☐ No dreams
- ☐ Daytime napping
- ☐ Excessive sleep (10+ hours per night)

MENTAL / EMOTIONAL HEALTH

What causes you stress *(e.g. money, work, relationships, health)?*

Do you ever experience the following? *(Please tick)*

- ☐ Palpitations
- ☐ Depression
- ☐ Mood swings
- ☐ High stress levels
- ☐ No motivation
- ☐ Addictive tendencies
- ☐ Poor concentration
- ☐ Excessive worrying
- ☐ Panic attacks
- ☐ Poor memory
- ☐ Feelings of overwhelm or unable to cope

DIGESTION

How often do you pass a bowel motion?

Do you have any food intolerances/allergies? ☐ Yes ☐ No

(If yes give details)

Do you ever experience any of the following? *(Please tick)*

- ☐ Loose stools
- ☐ Hard stools
- ☐ Difficulty passing a stool
- ☐ Nausea
- ☐ Blood in stools
- ☐ Excessive flatulence
- ☐ Undigested food in stools
- ☐ Burping
- ☐ Bloating
- ☐ Heartburn/reflux
- ☐ Abdominal pain
- ☐ Parasites
- ☐ Vomiting
- ☐ Abnormal thirst
- ☐ Difficulty swallowing
- ☐ Bad breath
- ☐ Burning anus
- ☐ Itchy anus
- ☐ Excessive wind/gas
- ☐ Haemorrhoids/Anal fissure
- ☐ History of gallstones or gallbladder attacks
- ☐ Crave sweet foods/coffee in the afternoon

Other: _____

CARDIOVASCULAR SYSTEM

- ☐ Chest pains
- ☐ Angina
- ☐ Palpitations
- ☐ Varicose veins
- ☐ High cholesterol
- ☐ High/low blood pressure
- ☐ Unusual swelling of ankles/feet
- ☐ Swollen wrists/hands
- ☐ History or current heart problems

FEMALE HEALTH

Age of first period

Are you sexually active? ☐ Yes ☐ No

Contraception? ☐ Yes ☐ No

(If yes give details)

Do you track your menstrual cycle? ☐ Yes ☐ No

How many days do you bleed for?

How long is your cycle (measured from first day of bleeding until the next bleed)?

Are you aware of ovulation? ☐ Yes ☐ No

Is there a chance you are pregnant? ☐ Yes ☐ No ☐ Trying to get pregnant

Are you pre-menopausal/menopausal? ☐ Yes ☐ No

Date of last pap smear?

Result of pap smear? ☐ Normal ☐ Abnormal

Recent pelvic ultrasounds? ☐ Yes ☐ No

Do you experience any of the following? *(Please tick)*

- ☐ PMS
- ☐ Irregular cycles
- ☐ Clots
- ☐ Cravings
- ☐ Heavy flow
- ☐ Mid-cycle bleeding
- ☐ Period pain
- ☐ Infertility
- ☐ Tender breasts
- ☐ Low libido
- ☐ No periods
- ☐ Itching
- ☐ Hot flushes
- ☐ Painful intercourse
- ☐ Sugar cravings
- ☐ Anxious
- ☐ Irritable
- ☐ Depressed
- ☐ Blood when passing urine
- ☐ Burning when passing urine

MALE HEALTH

Do you experience any of the following? *(Please tick)*

- ☐ Low libido
- ☐ Difficulty starting or stopping urine flow
- ☐ Premature ejaculation
- ☐ Testicular pain
- ☐ Difficulty maintaining an erection
- ☐ Prostate issues
- ☐ Infertility
- ☐ Low sperm count
- ☐ History or current heart problems

Other: _____

IMMUNE/RESPIRATORY

How many colds do you get per year?

How long does it usually take to recover?

Past infections e.g. glandular fever/ Herpes simplex virus/ chicken pox/ Strep throat/ UTIs / STIs?

Do you ever experience the following? *(Please tick)*

- ☐ Low resilience
- ☐ Mouth ulcers
- ☐ Persistent cough
- ☐ Allergies
- ☐ Post nasal drip
- ☐ Sinus congestion/inflammation

In your lifetime, how many courses of antibiotics have you received?

- ☐ 0 – 4
- ☐ 5 – 9
- ☐ 10 – 14
- ☐ 15+

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Muscle aches
- ☐ Headaches
- ☐ Joint stiffness after rising
- ☐ Muscle cramps

DIET

Do you follow a particular diet?
(e.g.: vegan, vegetarian, FODMAPs)

How long for?

Water per day: ml. Tap/bottled/filtered/rainwater:

Coffee per day: cups/day.

Tea/Herbal Tea per day: cups/day. Type:

Alcohol per week: Std drinks/week

Others: fruit juice/soft drinks/sport drinks/milk drinks: How many glasses per day?

Please provide an outline of your typical diet *(be as accurate & honest as possible – no judgement here folks!)*

Breakfast		Time:
Snacks		Time:
Lunch		Time:
Snacks		Time:
Dinner		Time:
Snacks		Time:

Cravings (sweets, salt, pastries, fried foods, chocolate etc.):

Aversions / Dislikes:

Do you have an appetite in the morning? ☐ Yes ☐ No

Do you ever skip meals? ☐ Yes ☐ No

(If yes, how many per week?)

How often do you go out/eat takeaway?

Do you sit down to eat with no distractions? ☐ Yes ☐ No

Do you eat on the go/standing up/at your desk? ☐ Yes ☐ No

LIFESTYLE

Exercise Type:

How often?

Relaxation Type:

How often?

Household/Living Situation

Do you use natural cleaning and personal hygiene products? ☐ Yes ☐ No

RECREATIONAL DRUGS

Do you take recreational drugs? ☐ Yes ☐ No

Have you in the past? ☐ Yes ☐ No

Type / How often / How much?

SMOKING HISTORY

☐ Non-Smoker ☐ Ex-Smoker ☐ Current Smoker

Number of smokes per day

Age started

Year quit

Please list any other information you feel is relevant below:

This information is collected for clinical and contact purposes only.

Please email this questionnaire along with any other relevant documents, e.g. pathology results, to **admin@yerongachiropractic.com.au** as soon as possible.

Thank you for taking the time to complete this form.

Melissa Le Breton – Naturopath

yeronga chiropractic & wellness centre