CONFIDENTIAL PRE-CONSULTATION HEALTH QUESTIONNAIRE

Date:_____

NAME:_____

GENDER : M / F **D.O.B:** _____

ADDRESS:_____

PHONE: HOME: _____ **MOBILE:** _____

EMAIL: _____

OCCUPATION: _____

EMERGENCY CONTACT:

NAME: _____**RELATIONSHIP:** _____

PHONE: _____

Why have you come to see us?_____

What is bothering you most? _____

What would you like to get out of our meeting?

_____

What do you think is the worst aspect of your health?

_____

What do you think is the best aspect of your health?

_____

Other Current Medical Issues:_____

_____

PREVIOUS HEALTH CARE: (circle)

Medical Chiropractic Acupuncture Naturopath Other

Name of Practitioner_____

Have you had any:

Surgery – Hospitalisation_____

When _____

Do you:

Smoke: If yes, how much? _____ No I Quit: When? _____ No Never

Drink Alcohol: No Rarely Regularly Daily Have in the past

Take Recreational Drugs: No Rarely Regularly Daily Have in the past

Exercise: No Rarely Regularly Daily Have in the past

Are you exposed to chemicals at work? Yes No

If yes, please give details_____

Are you exposed to cigarette smoke? Yes No

Do you wear: contact lenses wear glasses

Medications:

Currently taking:

NAME OF MEDICATION	DOSAGE	START DATE:	PURPOSE OF MEDICATION

Previously taken:

NAME OF MEDICATION	DOSAGE	START DATE:	PURPOSE OF MEDICATION

Please tick the box if you are presently taking/receiving any of the following:

Aspirin/Paracetamol	Yes	No	Sometimes
Laxatives	Yes	No	Sometimes
Oral contraception	Yes	No	Sometimes
Hormone therapy (HRT)	Yes	No	Sometimes
Lithium	Yes	No	Sometimes
Antibiotics	Yes	No	Sometimes
Warfarin	Yes	No	Sometimes

Are you taking any vitamins, minerals or herbal supplements? If yes, please give details: _____

Are you allergic to any known substances? Yes / No If yes, please give details

_____

Do you currently or have you suffered from any of the following? (circle)

Allergies
Hayfever
Sinus
Tonsillitis

Oral Thrush
Throat Infections
Mouth Ulcers
Low Immunity
Thyroid issues

Bronchitis
Asthma
Breathing issues

Acne
Eczema
Psoriasis
Dandruff
Rashes (describe)
_____

Joint pain
Arthritis
Muscle pain
Muscle cramps

Indigestion
Reflux
Bloating
Constipation
Diarrhoea
Irritable Bowel Syndrome
Crohn's disease
Ulcerative colitis
Nausea/vomiting
Stomach ulcers

Low energy/fatigue
Black moods
Migraine
Depression
Anxiety
Headaches
Insomnia
Nervous tension
Epilepsy

Endometriosis
Polycystic ovarian syndrome
Painful periods
PMS
Vaginal infections
Prostatitis
Low libido
Night sweats
Menstrual problems (describe)
_____

Fatigue
Headaches
Frequent infections

Low Blood Sugar
High Blood Sugar
Diabetes
Heart disease
High blood pressure
Low blood pressure
Varicose veins
Leg ulcers

Haemorrhoids
Urinary problems
Fluid retention
Weight gain

Cancer: Type: _____ Other: _____

Please detail all **health issues** that have occurred in your life **from your earliest remembered age**. You may be able to gain some of this information from your parent(s). It is sometimes easier to recall this detail by thinking through the various stages of our life. Please note approximate year and/or age in each instance.

Birth to preschool (0-5 years):
(childhood infections etc)

Primary school (5 – 11 years):

Secondary school (12 – 18 years):

20's:

30's:

40's:

50's+:

Family History: Please note any serious or chronic illnesses in your family history

Father_____ **Mother**_____

Siblings _____

Extended Family_____

Please detail all food and beverages consumed for **7 straight days** including number and/or amount of each item This information is used to evaluate the nutritional value of what you consume on a daily basis as well as identify the types of food and drink you enjoy so that any recommendations made are better suited to your preference.

On rising:	Time: ……
Breakfast:	Time: ……
Morning Tea:	Time: ……
Lunch:	Time: ……
Afternoon Tea:	Time: ……
Pre-dinner:	Time: ……
Dinner:	Time: ……
Before bed:	Time: ……
What time did you go to bed?	How long before you went to sleep?

Print one of these off for each day if possible

INFORMED CONSENT FORM

Integrative medicine is a form of holistic medicine using herbs, nutrition, diet and lifestyle to effect change in the whole body as well as incorporating regular medicines from your other health professionals. Your Integrative health practitioner (IHP) will take a thorough case history and may perform pertinent physical exams and suggest blood tests or request copies of blood tests previously completed by your doctor or specialist.

It is very important that you inform your IHP of any disease process that you are suffering from and any medications or over the counter drugs that you are taking. Please advise your IHP if you are nursing, are pregnant or become pregnant throughout the course of your treatment.

As a patient you will receive information about your diagnosis and/ or treatment, alternative courses of action, costs, benefits, risks, side effects and in each case, the consequences of not having the diagnosis and/ or treatment acted upon.

I understand that a record will be kept of the health services provided to me. The record will be kept confidential and will not be released to others unless so directed by myself or if the law requires it. If required, I understand that my IHP may discuss my case with other healthcare providers. If laboratory tests done through this clinic, I consent to having them published on Testsafe and being available to other health practitioners. I also understand I may opt out of this service if I wish to prevent the results being available on Testsafe.

Whilst Mark Webster is also a registered pharmacist, I understand that he is working with me as an integrative health practitioner and that all advice and treatments should be accepted in that capacity only. I understand that results are not guaranteed. I do not expect my IHP to be able to anticipate and explain all risks and complications. As with any form of medical intervention, there can be risks associated with treatment by naturopathic/integrative medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reaction to supplements or herbs

With this knowledge, I voluntarily consent to Integrative medical care. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name: (please print name)_____

Signature of patient or guardian:_____

Mark Webster (Practitioner) :_____