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NATUROPATHY

Patient Intake Form **CONFIDENTIAL**

Section 1: Personal & medical history

First name:		Surname:
Address:		
Suburb:	State:	Post code:
Telephone:	AH:	Mobile:
Email:		Sex:
Date of birth:	Place of birth:	
Occupation:		Blood type:
Marital status:	Dependants: #	
Emergency Contact:		Telephone:
Private health insurance provider:		
How did you hear about our clinic?		
Would you like to receive clinic information via email	Yes ☐	No ☐
Your health care providers (GP, specialists, allied health, other)		
Name:	Profession:	Contact no.:
Name:	Profession:	Contact no.:
Name:	Profession:	Contact no.:

A detailed health history improves the provision of Naturopathic healthcare.

What are the main health issues concerning you today?

If a chronic health concern, how long have you had this condition?

Treatment(s) to date:

Have you had any major health issues in the past? If yes, please briefly list.

If female:

Are you currently pregnant? Yes ☐ No ☐ Attempting to conceive? Yes ☐ No ☐ Lactating? Yes ☐ No ☐

List all current prescription medications (including the oral contraceptive pill if relevant)

Name	Dose	Since when	Reason

List all current non-prescription medications including dosage & frequency (e.g. Panadol, Aspirin, Anti-histamine, Laxatives, Antacids, Anti-inflammatories etc.)

List all current natural medicines including vitamins, herbs, other (include those you take more than occasionally and note brand, dosage and reason why taking)

Known Allergies (please tick relevant)
Dairy ☐ soy ☐ wheat ☐ yeast ☐ gluten ☐ lactose ☐ artificial flavourings/colourings ☐
metal jewellery ☐ band aids ☐ latex ☐ rubber ☐ dust mites ☐ grasses ☐ pollen ☐
fur ☐ medicines (please detail) ☐
Other:

Are you a current cigarette smoker: Yes ☐ No ☐
If yes, how many cigarettes do you smoke per day?

Past smoking history: Nil ☐ Light ☐ Moderate ☐ Heavy ☐ Date ceased smoking:

Did you have any major illnesses as a child/adolescent?

Have you ever required hospitalisation? If yes, when and for what reason?

Have you received antibiotics with in the past 3 years? Yes ☐ No ☐

Have you travelled overseas within the past 12mths? Yes ☐ No ☐

If yes, where did you travel?

Section 2: Family medical history

Do/Did your siblings, parents and/or grandparents suffer from the following (please tick relevant):

Diabetes ☐	Thyroid disease ☐	Allergies ☐	Arthritis ☐	Depression ☐
ADHD ☐	Kidney disease ☐	Hepatitis ☐	Hypertension ☐	High cholesterol ☐
Hay fever ☐	Asthma ☐	Sinus ☐	Liver disease ☐	PCOS ☐
Autoimmune – Lupus, MS, Crohn's ☐		Endometriosis ☐	Fibroids ☐	Cancer ☐

Other:

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Health Appraisal Questionnaire Please tick (✓) if you currently or recently experienced:

Skin	**Y**
Rash	☐
Eczema	☐
Psoriasis	☐
Acne	☐
Cuts	☐
Bruising	☐
Slow healing	☐
Other:	
Eyes, nose, ears, mouth	**Y**
Blurred vision	☐
Tinnitus	☐
Nose bleeds	☐
Ear ache/infect	☐
Hay fever	☐
Runny nose	☐
Sinus	☐
Cold sores	☐
Mouth ulcers	☐
Loss of taste	☐
Other:	
Head & Throat	**Y**
Headaches	☐
Migraines	☐
Problems swallowing	☐
Sore throat	☐
Dizziness	☐
Other:	
Respiratory	**Y**
Frequent cough	☐
Asthma	☐
Bronchitis	☐
Difficulty breathing	☐
Pain on breathing	☐
No. colds pa	☐
Other:	

Digestive	**Y**
Indigestion	☐
Burping	☐
Bloating	☐
Heartburn	☐
Change in appetite	☐
Bad taste in mouth	☐
Bad breath	☐
Flatulence	☐
Abdominal pain	☐
Itchy anus	☐
Haemorrhoids	☐
Gallbladder disease	☐
Hiatus hernia	☐
Food allergy	☐
Food intolerance	☐
Ulcers	☐
Thrush/candida	☐
Nervous 'butterfly' stomach	☐
Other:	
Bowels	**Y**
Diarrhoea	☐
Constipation	☐
How often do you pass a bowel motion (daily, weekly etc)	
Is your bowel motion:	
Well formed	☐
Loose	☐
Made up of lots of pieces	☐
Difficult to pass	☐
Pale coloured	☐
Dark, black coloured	☐
Any pain, bleeding or mucous with bowel motion?	☐
Do you used laxatives	☐
Other:	

Heart/Blood	**Y**
Anaemia	☐
Angina	☐
Chest pain	☐
Oedema	☐
Palpitations	☐
High blood pressure	☐
Low blood pressure	☐
Varicose veins	☐
High cholesterol	☐
Numbness/tingling	☐
Lightheaded	☐
Shortness of breath	☐
Other:	
Musculoskeletal	**Y**
Joint pain	☐
Joint stiffness	☐
Muscle aches & pains	☐
Gout	☐
Restless legs	☐
Arthritis (RA or OA?)	☐
Other:	
Urinary	**Y**
Pain/burning on urination	☐
Increased frequency	☐
Frequency at night	☐
Frequent infections	☐
Kidney stones / problems	☐
Blood in urine	☐
Incontinence	☐
Other:	

Endocrine	**Y**
Unexplained weight gain /loss	☐
Always cold	☐
Always hot	☐
Cold hands/feet	☐
Thyroid problems	☐
Diabetes	☐
Increased thirst	☐
Increased hunger	☐
Increased sweating	☐
Other:	
Other conditions	**Y**
Glandular fever /EBV	☐
HSV 1, 2	☐
Epilepsy	☐
Cancer	☐
Shingles	☐
Hepatitis	☐
Malaria	☐
Lyme	☐
HIV/AIDS	☐
Other:	
Male Reproduction	**Y**
Loss of libido	☐
Discharge	☐
Testicular mass /pain	☐
Ant STI's?	☐
Difficulty starting or maintaining urinary flow	☐
Other:	

Female reproduction	**Y**
Age of menarche	
Length of menstrual period (days)	
Date of last menstrual period	
Do you experience:	
Clots	☐
Heavy blood loss	☐
Painful periods	☐
Spotting between periods	☐
Current OCP use	☐
Irregular cycles	☐
Pain during/after sex	☐
Vaginal itchiness	☐
Vaginal discharge Any lumps or pain in breasts?	☐
STIs (past or current)	☐
PMS e.g. bloating, cravings, tender breasts, irritation, emotional lability?	☐
If you have children did you have any difficulties with pregnancy/s or labour?	☐
Reduced libido	☐
Do you have:	
PCO or PCOS?	☐
Endometriosis?	☐
Fibroids?	☐

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Confidentiality
Health information collected will be kept in accordance with *The Health Records Act 2001 (VIC)*. Patients may access their health information in accordance with the Act. There are occasions where a case discussion between professional practitioners may improve the quality of care provided to you. You consent to the discussion of your de-identified case details between professional practitioners to enhance your treatment outcomes.
Privacy
Only relevant personal information will be collected and this information will only be shared with your consent or to comply with regulatory and legal requirements such as court orders. Your personal information may be used to: assess your health concerns and provide quality health care and follow up; maintain contact and provide clinic information; communicate with your other healthcare providers under a shared care model; complete private health insurance claims; invoice you for goods and services; process credit card and EFTPOS payments and collect unpaid accounts.
Scope of Practice
Naturopath's are not primary care physicians and treatment provided is not intended to supersede recommendations or treatment provided by other registered health care professionals. Your Naturopath seeks to work in a shared care model to complement your existing healthcare. Naturopathic treatment may include natural medicine such as herbs, vitamins, minerals, flower essence & homeopathic remedies, and dietary and lifestyle advice.
Your obligations
Please ensure your Naturopath is aware of all medications taken and therapies you are receiving to identify and avoid potential adverse interactions. Female patients must advise your Naturopath if you are pregnant, trying to conceive or lactating as some treatments may be contraindicated in those circumstances. Some natural medicines may contain alcohol, crustaceans, dairy or meat by-products. Please advise your Naturopath if you have religious/other reasons to avoid these substances.
Adverse reactions
Natural medicines may cause unforeseen health risks including but not limited to a temporary aggravation of pre-existing conditions or allergic reaction to herbs or supplements. Should you experience an adverse reaction please contact your Naturopath. In case of an emergency, contact 000 or proceed to the Emergency Dept at your nearest hospital.
Cancellation Policy
Appointments missed or not cancelled within 24hrs notice will incur a 50% cancellation fee, charged at the next appointment. We acknowledge that your time is as important as ours and will extend a 50% discount on a rescheduled appointment should we have to cancel a booking within 24hrs of the scheduled time.

Statement of acknowledgement and consent

I, _____ have read, understood and agree to the contents herein.

Patient signature: _____ Date: _____/_____/_____

(If under 18 years, parent or guardian to sign)

Thank you for taking the time to complete this form.

Submit