radiance
HEALTHCARE CENTRE

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Confidential Naturopathic New Patient Questionnaire

In order for us to provide you with quality naturopathic care, please provide us with the following information regarding your present state of health and medical history. Please note that all of this information is required by us to make our assessment of your naturopathic needs and to provide you with the necessary naturopathic care.

Name **Date**

Address

Suburb **Postcode** **State**

Home Ph **Work** **Mobile**

Email address

Birth date **Age** **Blood type**

Have you previously received Naturopathic Care?

How did you hear about our clinic?
☐ Friend ☐ Natural Therapy Pages ☐ Yellow pages ☐ Google ☐ Internet ☐ Other

☐ Tick if you would **not** like to receive our Newsletter

What are the main reasons you have sought naturopathic health for: (Select as many as you wish)

☐ Weight loss ☐ Disease Prevention ☐ Pre-conception care ☐ Cardiovascular protection
☐ Diet ☐ Energy ☐ Immune system ☐ Sports enhancement
☐ Specific health concern_____

What are your expectations for today's consultation?

Goals & Expectations

How do you rate your present level of health?
Rate 1-10, 10 being excellent ( )

How do you rate your present level of energy or vitality?
Rate 1-10, 10 being excellent ( )

How committed are you to improving your health?
Rate 1-10, 10 being highly committed ( )

How confident are you in making suggested dietary, lifestyle and exercise modifications to improve your health and wellbeing?
Rate 1-10, 10 being highly confident ( )

Are you willing to make changes to your diet and lifestyle to improve your health?
☐ Yes ☐ No ☐ Maybe

Are you willing to increase your aerobic capacity with an exercise program?
☐ Yes ☐ No ☐ Maybe

Are you willing to increase your strength and stamina with a strength resistance training program?
☐ Yes ☐ No ☐ Maybe

How long do you feel it would take you to achieve your health and lifestyle goals?
☐ Days ☐ Weeks ☐ Months ☐ Years

What do you think could stop you from achieving your health goals?
☐ Time ☐ Interest ☐ Support ☐ Money ☐ Commitment ☐ Health ☐ Other

Main Concern

Please describe your main health complaint

When did this condition develop

Blood tests or other tests performed

Current treatment (if any)

Other Concerns

Please list any other health concerns you may have that you would like to improve

Past Medical History

Please list any surgeries, fractures, accidents or serious illnesses

Frequency of colds/flu per year
Number of antibiotics taken per year
Date of last physical examination by a doctor
Date of last blood tests
Other tests performed and the year (ie endoscopy, colonoscopy, ultra sound)

Lifestyle, Medications and Supplements

Do you exercise	☐ Never	☐ 1-2 times/week	☐ 3-4 times/week	☐ Every day
Do you smoke?	☐ Yes	☐ No	Number smoked per day	
Do you drink alcohol?	☐ Yes	☐ No	How many standard drinks per week?	
Do you take recreational drugs?	☐ Yes	☐ No	Type and frequency	

Please list all medications you are currently taking (including the pill, laxatives and warfarin) along with the dosage

Please list all herbal or vitamin supplements you are currently taking (include brand and dose)

GENERAL

Please tick the imbalances below that apply to you

- ☐ Excessive gas
- ☐ Indigestion
- ☐ Bloating
- ☐ Crave sugar/carbohydrates
- ☐ Diarrhoea
- ☐ Constipation
- ☐ IBS
- ☐ Blood in bowel movements
- ☐ Haemorrhoids or piles
- ☐ Bad breath/bad body odour
- ☐ Antibiotic 1 time/year or more
- ☐ Long term antibiotic use
- ☐ Use of birth control pill
- ☐ Athletes foot, tinea, fungal infections
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Cystitis (burning urine)
- ☐ Incontinence
- ☐ Cancer

- ☐ Headaches
- ☐ Neck pain
- ☐ Tension across shoulders
- ☐ Depression
- ☐ Anxious
- ☐ Moody
- ☐ Nervousness
- ☐ Irritability
- ☐ Aggressive/angry
- ☐ Tired, Fatigued
- ☐ Wake up feeling tired
- ☐ Tired after lunch
- ☐ Mental confusion/forgetful
- ☐ Hard to get to sleep
- ☐ Wake during night
- ☐ Startle easily
- ☐ Muscle cramps/sprains
- ☐ Numbness/Tingling arms/legs
- ☐ Loss of smell/taste
- ☐ Generally feel stressed
- ☐ Sigh or yawn excessively
- ☐ Known allergies

- ☐ Shortness of breath
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Heart conditions
- ☐ Weight trouble
- ☐ High cholesterol – current or past
- ☐ Cold hands/feet
- ☐ Sensitive to the cold
- ☐ Cracked lips, hands or feet
- ☐ Split fingernails
- ☐ Mouth ulcers or a form of herpes
- ☐ Blocked sinuses
- ☐ Mucus that is white in colour
- ☐ Mucus that is green in colour
- ☐ Asthma
- ☐ Dandruff
- ☐ Easily catch colds & flu
- ☐ History of anaemia/B12 deficiency
- ☐ Thyroid disorder
- ☐ Fluid retention
- ☐ Family history of coeliac disease

Specific female conditions

- ☐ PMT
- ☐ Congested breasts
- ☐ Reduced sex drive
- ☐ Painful menstruation
- ☐ Ovarian cysts
- ☐ STD's

- ☐ Excessive menstruation
- ☐ Irregular cycle
- ☐ Vaginal discharge
- ☐ Pass large clots of blood
- ☐ Endometriosis
- ☐ Genital warts

- ☐ Menopausal symptoms
- ☐ Hot flushes
- ☐ Hysterectomy or removal of ovaries
- ☐ Retain fluid in breasts/belly
- ☐ Abnormal PAP smear
- ☐ Itchiness

Date of last PAP smear

Date of last ultrasound

Please list any gynaecological procedures you may have had ie cone biopsy, LEEP, ultrasound, laproscopy

What form of contraception are you currently using?

If one the pill, which one?

Have you taken the contraceptive pill? If so for how long?

Are you pregnant or is there a possibility you are pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Specific male conditions

- ☐ Prostate problems
- ☐ Groin pain
- ☐ Impotence
- ☐ Pain in testicles
- ☐ Reduced sex drive
- ☐ Difficulty in urinating or a reduction in flow

Frequency of bowel movements

☐ Multiple times/day (how many ____) ☐ Daily ☐ Every 2nd–3rd day ☐ Once a week ☐ Once a fortnight

Straining ☐ Yes ☐ No Blood ☐ Yes ☐ No Mucus ☐ Yes ☐ No

DIET

Please list below the foods and beverages you would consume in an average day. Please be as honest as possible and include in this list biscuits, chocolate and soft drinks and other snack foods!

Breakfast

Mid morning snack

Lunch

Afternoon snack

Dinner

Evening snack

Cups of tea/day		# of sugar's		# of soft drinks per day	
Cups of coffee/day		# of sugars		# of fruit juice per day	
Amount of water/day		Glasses or Litres			

FAMILY HISTORY

Please give brief details of your family's past and present health problems especially relatives that have or take medication for diabetes, hypertension, cardiovascular disease, high cholesterol, coeliac disease, stroke and/or cancer.

Relative	Alive or deceased	Health condition

Informed consent for naturopathic care

I declare that the above information is true and correct and indemnify Harmonious Wellbeing Pty. Ltd trading as Radiance Healthcare Centre and any of its contractors and employees of any liability for any false or misleading statements given.

I understand and accept that the naturopathic treatment received by your office is of a holistic therapeutic nature and does not attempt to diagnose or treat disease. I also understand and accept that the Cellular Health Analysis, Live Blood analysis or any other tests performed by the clinic are not diagnostic in any way.

I understand and accept that data collected about myself during this consultation and subsequent consultations will remain the property of Harmonious Wellbeing, as part of case history records. This information will remain private and confidential.

I understand that the above information about me is collected by Harmonious Wellbeing; who can be contacted on 02 9247 4633 should I wish to gain access to the information including for the purpose of correcting and updating such information.

Name **Date**

Signature