# 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
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):

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 (**please see example page at end of this document**). 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? |

STAY WELL PHARMACY

# INFORMED CONSENT FORM

Naturopathic 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 practitioner 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 Naturopath/Pharmacist of any disease process that you are suffering from and any medications or over the counter drugs that you are taking. Please advise your Naturopathic Pharmacist 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 naturopathic pharmacist may discuss my case with other healthcare providers.

I understand that results are not guaranteed. I do not expect naturopaths/naturopathic pharmacists 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 Naturopathic/Integrative 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 (Naturopathic Pharmacist)

Signature:_____