NATUROPATHIC HEALTH PATIENT INFORMATION

This information is strictly confidential

Date:_____

First Name:_____ Surname:_____

Address: _____Postcode:_____

Phone No: (H)_____(W or Mob.)_____

E-mail address:_____Age: _____

Date & Place of birth:_____ Marital status: _____

Occupation:_____No. Children: _____

Name of Private health insurer:_____

How did you find out about us? _____

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Symptoms & Health problems you require treatment for: _____

_____

_____

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Medical diagnosis: _____

Name of Doctor: _____

Medical treatment & medications: _____

Surgery: _____

Previous Naturopathic treatment: _____

_____

Women Only:

Do you suffer from menstrual problems: Yes / No. Are you and have you taken the contraceptive pill. Yes / No

Have you been pregnant: Yes / No. If yes, when: _____

Have you ever taken any of the following: If yes, please specify drug name if known – and when you last took them:

Antibiotics: _____Steroids: _____

Antidepressants: _____Tranquilisers: _____

Sleeping tablets: _____Cortisone: _____

Vitamins and Minerals: _____

_____

Social Drugs: _____

Have you ever suffered from: (tick if you've had it previously or circle if currently a problem.)

Asthma	Jaundice	Migraines	Dysentry	Bronchitis	Malaria
Pneumonia	STD's	Chicken pox	Measles	Rheumatic fever	Tuberculosis
Cystitis	Mumps	Scarlet fever	Whooping cough	German measles	Kidney problems
Sinus	Insomnia	Diarrhoea	Constipation	Cold hands / feet	Glandular fever
Cancer	Diptheria	Varicose veins			

Please turn over

Family Health: Do you have Amalgam(mercury) Fillings? yes/no

Mother:_____

Father: _____

Sister:_____

Brother: _____

Have any of your Relatives suffered from: (Please Tick)

Asthma	Epilepsy	Mental Trouble	Eczema/Psoriasis
Cancer	Heart Trouble	Rheumatic Fever	Neurosis
Diabetes	Kidney Trouble	Tuberculosis	Arthritis

General Comments you feel to be important to your Health:

_____

_____

_____

Height:_____ Weight: _____ Blood Pressure: R/A L/A:

Alcohol intake:_____Cigarettes:_____

Water: (Filter, Rain, Spring, Tap) ; How much per day: _____

Daily intake of - Coffee:_____ Tea:_____ Soft Drinks: _____ Milk:_____

Example Of Diet:

Breakfast: Lunch: Dinner: Between:

Cravings:_____

Exercise: Yes / No. What type & How often:_____

_____

I herby give consent to receive Naturopathic treatment in this clinic. I am aware the clinic has a 24 hour cancellation policy. If I am unable to keep an appointment, I will give at least 24 hours notice; otherwise I understand that a $45 cancellation fee may apply.

Signed:_____ Date:_____