CONFIDENTIAL PATIENT QUESTIONNAIRE

Please complete the following questionnaire. Your response remains confidential and will provide information for your practitioner to use in your assessment and treatment.

Practitioner: ______________________________ Appointment Date: ____/____/____Time:____:____

Title			Date of Birth		
First / Second Names			Surname		
Home Address					
Suburb/Town			State		Postcode
Home: ( )		Work: ( )		Mobile:	
Medicare Number (exp.)			Private Health Fund		
Email Address					
Height (cm)	Weight (kg)		Would you like to subscribe to our online newsletter? YES / NO		
Next of Kin		Relationship		Telephone No:	
How did you hear about YourHealth? Please circle the category below.					

Advertisement	Article	Brochure / Flyer / Poster	Direct Mail	Email Newsletter
Expo-Conference	Friend / Relative / Colleague	Gift Voucher-Prize	Orion Corporate Health	Pharmacy / Health food store
Practitioner referral	Seminar	TV / Radio	Walk-by-Signage	Website
Local GP Details if applicable		GP Name		
GP Address			GP Phone Number	

GENERAL DETAILS

Please list the main problems you are experiencing and/or reasons for this appointment.

____

____

____

____

What do you believe the problem may be due to?

____

____

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What kind of treatment(s) have you tried for the problem(s) listed above? *Please detail any relevant testing or investigations and bring relevant copies with you to your consultation.*

When was the last time you felt truly well?

What do you expect from your consultation today?

What do you think can help you?

PAST MEDICAL HISTORY
Please circle as appropriate.

Illness/Medical Problem	**Present**	**Past**
Heart/Vascular Disorder	YES	YES
Blood disorder	YES	YES
High blood pressure	YES	YES
Cancer	YES	YES
Arthritis	YES	YES

Diabetes	YES	YES
Liver disease	YES	YES
Kidney disease	YES	YES
Asthma	YES	YES
Epilepsy	YES	YES
Hepatitis	YES	YES
Glandular fever	YES	YES
Dysentery	YES	YES
Sexually Transmitted Diseases *Please specify.*	YES	YES
Other conditions *Please specify.*	YES	YES
Operations *Please specify.*	YES / NO	YES / NO
Pregnancies	YES / NO	YES / NO
Exposure to chemicals or toxins *Please specify.*	YES / NO	YES / NO
Amalgam fillings	YES / NO	YES / NO
Frequent Antibiotic Use	YES / NO	YES / NO
Previous long-term medications (including contraceptive pill)	YES / NO	YES / NO

SCREENING/PATHOLOGY HISTORY

Screening Test / Pathology	Date	Result
Mammogram / Breast Ultrasound		
Pap Smear		
Bone Density		
Cholesterol		
PSA (Prostate Blood Test)		

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NUTRITIONAL SUPPLEMENTS (vitamins, minerals etc.), HERBAL MEDICINES, HOMOEOPATHIC REMEDIES

Name	Dosage

CURRENT MEDICATIONS (prescription and non-prescription)

Name	Dosage

ALLERGIES / SENSITIVITIES (including medications, foods, dust mites, grasses, chemicals)

Allergies / Sensitivities	Treatment

SOCIAL HISTORY

Occupation	
Marital Status	
Cigarettes / Tobacco (strength & amount/day)	

Alcohol (type & amount/day)	
Recreational Drugs	
Exercise (type, duration & frequency)	
Relaxation Techniques (e.g. meditation, yoga, tai chi)	

DIET

Do you follow a specific type of diet? *Please circle.*	**YES / NO**
If yes, please specify. *(eg. Low fat, low carbohydrate, blood group, vegetarian etc.)*	

What did you eat yesterday? *Please complete the table below.*

Breakfast			
Lunch			
Dinner			
Snacks			
Sugar (tsp/day)	Tea (cups/day)	Coffee (cups/day)	Soft Drinks(per day)
Water (glasses/day)		Other Drinks	

Was this a typical day? *Please circle*. YES / NO

Please list the foods that you **CRAVE.**	Please list the foods that you **AVOID.**

IMMUNISATION HISTORY Please record any immunisations you have received.

TYPE	DATE	TYPE	DATE

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CURRENT SYMPTOMS

Please tick the box to the right of any condition you are ***CURRENTLY EXPERIENCING***.

GENERAL		WEIGHT		NERVOUS SYSTEM		EYES		EARS	
Fatigue		Weight gain		Headaches		Watery/itchy		Itchy	
Apathy/lethargy		Difficulty losing weight		Migraines		Painful/red		Ear aches	
Hyperactivity		Fluid retention		Faintness		Sticky eyelids		Infections	
Poor appetite		Binge eating		Dizziness		Blurred vision		Discharge	
Hypoglycaemia		Compulsive eating		Numbness		Deteriorating vision		Tinnitus (ringing)	
Poor sleep/insomnia		Craving for certain foods		Tingling, pins & needles		Dry eyes		Hearing loss	
Sleep apnoea		Weight loss		Poor co-ordination					
Excessive thirst		Eating disorders		Feel cold easily					
Stress				Cold hands & feet					
Easy bruising									

DIGESTIVE SYSTEM		HEART/CIRCULATION		LUNGS		GYNAECOLOGICAL		GENITO-URINARY	
Indigestion		High blood pressure		Shortness of breath		PMT (pre-menstrual syndrome)		Frequent urination	
Heartburn/reflux		Low blood pressure		Cough		Breast pain		Passing large amounts of urine	
Bloating		High cholesterol		Sputum		Breast lumps		Burning / discomfort on urination	
Feel full easily		Chest pain		Blood		Breast implants		Discharge	
Burping		Palpitations/arrhythmia		Chest tightness		Regular periods		Blood in urine	
Flatulence		Swelling of ankles		Wheeze		Irregular periods		Urgent urination	
Abdominal/stomach pains or cramps		Poor circulation				No periods		Kidney pain	
Nausea		Calf pain with exercise				Heavy periods		Difficulty passing urine	
Vomiting		Varicose veins				Menstrual clots		Passing urine frequently at night	
Difficulty swallowing						Period pain/cramps		Incontinence	
Diarrhoea						Painful intercourse		Loss of libido	
Constipation						Vaginal irritation/soreness		Erectile dysfunction (impotence)	
Piles (haemorrhoids)						Vaginal discharge			
Mucus						Thrush			
Rectal bleeding						Menopausal			
Anal itching						Hot flushes			
						Sweats			
						Vaginal dryness			

HISTORY continued

NOSE		MOUTH / THROAT		SKIN		HAIR / NAILS		JOINTS / MUSCLES	
Congested/blocked		Mouth ulcers		Acne/pimples		HAIR		Pain	
Poor sense of smell		Cold sores		Eczema/dermatitis		Dry Hair		Swelling	
Sinus problems		Cracks at corner of mouth		Psoriasis		Increased hair loss		Stiffness	
Hay fever/allergy		Sore throat		Rosacea				Arthritis	
Sneezing		Hoarseness, loss of voice		Rashes		NAILS		Neck problems	
Excessive mucus		Gum disease/bleeding		Hives/urticaria		Soft		Back problems	
Post-nasal drip		Feeling of lump in throat		Dry skin		Break easily		Cramps / spasms	
		Loss of taste sensation		Poor healing		White spots		Muscle twitching	
		Bad breath		Excessive sweating		Ridged		Muscle tension	
				Body odour		Fungal infections		Muscle weakness	
				Dandruff				Gout	

EMOTIONS		MIND	
Anxiety		Poor memory	
Depression		Poor concentration	
Mood swings		Confusion	
Panic attacks		Poor comprehension	
Anger, irritability		'Brain fog'	

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Please complete the chart below indicating only chronic or significant illnesses (eg. Cancer, diabetes, asthma, arthritis, heart disease and blood pressure) within the appropriate box on the family medical history tree.

FAMILY HISTORY

GRANDFATHER

GRANDMOTHER

GRANDFATHER

GRANDMOTHER

FATHER

MOTHER

AUNT / UNCLE

AUNT / UNCLE

AUNT / UNCLE

AUNT / UNCLE

AUNT / UNCLE

AUNT / UNCLE

YOU

BROTHER/SISTER

BROTHER/SISTER

BROTHER/SISTER

BROTHER/SISTER

SON

DAUGHTER

SON

DAUGHTER

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METABOLIC SCREENING QUESTIONNAIRE

Please rate each of the following symptoms based upon your health profile for the past 30 days.

0 = Never or almost never have the symptom.
1 = Occasionally have it, effect is not severe.
2 = Occasionally have it, effect is severe.
3 = Frequently have it, effect is not severe.
4 = Freqently have it, effect is severe.

Category	Symptoms	Total
DIGESTIVE TRACT	___ Nausea or vomiting ___ Diarrhea ___ Constipation ___ Bloated Feeling ___ Belching, or passing gas ___ Heartburn ___ Intestinal / Stomach pain	**Total** ___
EARS	___ Itchy Ears ___ Earaches, ear infections ___ Drainage from ears ___ Ring in ears, hearing loss	**Total** ___
EMOTIONS	___ Mood swings ___ Anxiety, fear or nervousness ___ Anger, irritability, or aggressiveness ___ Depression	**Total** ___
ENERGY / ACTIVIY	___ Fatigue, slugglishness ___ Apathy, lethargy ___ Hyperactivity ___ Restlessness	**Total** ___
EYES	___ Watery or itchy eyes ___ Swollen, reddened or sticky eyelids ___ Bags or dark circles under eyes ___ Blurred or tunnel vision (does not include near or far sightedness)	**Total** ___
HEAD	___ Headaches ___ Faintness ___ Dizziness ___ Insomnia	**Total** ___
HEART	___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat ___ Chestpain	**Total** ___
JOINTS / MUSCLES	___ Pain or aches in joints ___ Arthritis ___ Stiffness or limitation of movement ___ Pain or aches in muscles ___ Feeling of weakness or tiredness	**Total** ___
LUNGS	___ Chest congestion ___ Asthma, bronchitis ___ Shortness of breath ___ Difficulty breathing	**Total** ___

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MIND	___ Poor Memory ___ Confusion poor comprehension ___ Poor Concentration ___ Poor physical co ordination ___ Difficulty in making decisions ___ Stuttering or stammering ___ Slurred speech ___ Learning disabilities	**Total** ___
MOUTH / THROAT	___ Chronic coughing ___ Gagging, frequent need to clear throat ___ Sore throat, hoarseness, loss of voice ___ Swollen or discoloured tongue gums, lips ___ Canker sores	**Total** ___
NOSE	___ Stuffy nose ___ Sinus problems ___ Hay fever ___ Sneezing attacks ___ Excessive mucus formation	**Total** ___
SKIN	___ Acne ___ Hives, rashes, or dry skin ___ Hair loss ___ Flushing or hot flushes ___ Excessive sweating	**Total** ___
WEIGHT	___ Binge eating / drinking ___ Craving certain foods ___ Excessive weight ___ Compulsive eating ___ Water retention ___ Underweight	**Total** ___
OTHER	___ Frequent illness ___ Frequent or urgent urination ___ Genital itch or discharge	**Total** ___
GRAND TOTAL		___
COMMENTS:		

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General Acknowledgement and Consent Form

I, ____,

of____

understand that some of the diagnostic tests, treatments and products administered by practitioners at **YourHealth Manly** may be outside the parameters of conventional medicine in Australia. They fall into the category of Natural or Complementary Medicine. I understand that these diagnostic tests, treatments and products are supported by empirical knowledge, are safe, are widely and successfully used by Integrative Medical practitioners in centres in Australia and overseas, and are only prescribed with utmost care. Some diagnostic tests and treatments offered at YourHealth centres are not covered by Medicare or private health insurance funds. All YourHealth practitioners are members and active participants of their respective professional Colleges and Associations.

I am attending YourHealth Manly of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatment(s) made available to me. I understand that YourHealth practitioners may recommend and dispense items that are yet to be regulated by the Therapeutic Goods Administration (TGA), should the practitioner deem that such products or treatments are in my best interest. If there are any risks associated with using unregulated products or treatments, the YourHealth practitioner(s) will make me fully aware of those risks and provide me with sufficient information to make an informed decision.

Signed,

Patient's Name:	Witness's Name:
Signature:	Signature:
Date:	Date: