cindy biccard
naturopathic medicine

Comprehensive Health Assessment Form

PRIVACY & CONSENT INFORMATION

This clinic collects a variety of information from you and about you, which forms the basis of your health record and assists us with the determination of your health assessment to be used in the management and treatment of your condition. Your information will be treated with complete confidentiality as per the Privacy Act of 1988 (http://www.oaic.gov.au/privacy/the-privacy-act/).

In order to support your health needs, we ask that you complete all the relevant questions and supportive documents **48 hours prior to your consultation**. Should you not feel comfortable in divulging certain information, you may omit information or discuss this with your practitioner on the day of the consultation. This may mean that certain areas of your health may not be addressed which may not be beneficial for your desired health outcome. We also wish to state that we respect you privacy and would not want you to feel uncomfortable in any way.

Title

First Name *
Eeyn

Middle Name (if any)

Last Name *
Laine

Preferred Name

Date of Birth *
06/06/1983

Biological Gender *
- (●) Female
- ( ) Male

Phone Number *
0404022444

Email Address *
Erynlaine@gmail.com

Occupation *
HR advisor

Address *

Street address *
108 Moreton Downs Drive

Street address line 2 *
N

City *
Deception Bay

State *
QLD

Postcode *
4508

Emergency Contact Details

First Name of Emergency Contact

Chris

Last Name of Emergency Contact

Laine

Mobile phone of Emergency Contact

0438235565

Relationship to you

Mum

How did you hear about this practice *

Family or Friend

Medical History

Recent blood tests

Browse

If you have any recent blood tests (within the last 3 weeks), you may upload them here.

Have you ever been admitted to hospital or had any surgeries? *

- (•) Yes
- ( ) No

Are you currently under any medical treatment *

- (•) Yes
- ( ) No

Please list any surgeries you have had in the past or that is scheduled in the future with various dates:

2012 - C5-c6 laminectomy
2018 Spinal blocks same discs

Please list the surgeries and when they took place (month and year).

Do you have any known allergies? *

- (•) Yes
- ( ) No

Please list the allergy/ies and consequence

Dust, dander, grasses, perfumes, tea tree oil

Are you currently taking any medications (Please include all herbal and nutraceutical supplements). *

- (•) Yes
- ( ) No

Medication / Supplements - please provide the brand names where possible:

Celebrex 200mx
Mirtazipine 30
Valdoxan
Pristiq 200mg
Quetiapine 50-100mg
Pill

Please include the name of medication, dosage and the amount of times per day that it is taken.

Have you used any of the following medications in the last 6 months? *

Anti-acids

- [x] Yes
- [ ] No

Anti-diabetic / Insulin

- [ ] Yes
- [x] No

Anti-Histamines

- [ ] Yes
- [x] No

Anti-Inflammatories (Aspirin, Nurofen)

- [x] Yes
- [ ] No

Anti-psychotics

- [x] Yes
- [ ] No

Antibiotics

- [x] Yes
- [ ] No

Antidepressants

- [x] Yes
- [ ] No

Asthma preventer / inhaler

- [x] Yes
- [ ] No

Chemotherapy

- [ ] Yes
- [x] No

Heart medication

- [ ] Yes
- [x] No

High blood pressure medication

- [ ] Yes
- [x] No

Hormone modulators / Oral contraceptive pill

- [x] Yes
- [ ] No

Paracetamol

- [x] Yes
- [ ] No

Radiation therapy

- [ ] Yes
- [x] No

Sleeping medications / Relaxants

- [x] Yes
- [ ] No

Steroids

- [ ] Yes
- [x] No

Thyroid medication

- [ ] Yes
- [x] No

Are you currently smoking? *

- [x] Yes
- [ ] No

Are you seeking assistance in ceasing smoking *

- [x] Yes
- [ ] No

How many cigarettes are you smoking per day? *

- [ ] 1-8
- [x] 9-19
- [ ] 20+

Are you satisfied with your current weight? *

- [ ] Yes

What is your current weight? *

What is your height in cm? *

What is your ideal weight? *

- [x] No

Too heavy - 97 is my last we | 169 | 80

What are the main priorities in your health you would want addressed in the initial appointment? (Please list no more than 3) *

Gut health
Brain health

What is your level of commitment to apply suggested dietary and lifestyle changes to improve your health?

Ready ... whatever it takes!

Comprehensive Health Analysis

The following comprehensive questionnaire pertains to the various systems affected in your body and what you have been symptomatically experiencing in the last **3 months**. By answering the questions, a health 'roadmap' may be derived to assist you with the relevant treatment and strategies to improve your health and vitality. Together we will monitor the progress being made along with collaborative assistance from conventional and allied health practitioners to achieve your health goals.

In some instances questions may be repeated, please answer them all.

Digestive System - Stomach

Bad breath or foul taste in mouth *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Bloating during or directly after consuming food *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Excessive burping *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

History of low iron levels or anaemia *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Indigestion *
- [ ] Never
- [ ] Sometimes
- [x] Regularly
- [ ] Always

Loss of appetite *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Nausea *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Sensation of food stagnating after eating *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Alleviation from heartburn using antacids, carbonate, beverages, milk, or cream *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Constipation *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Difficulty or discomfort when swallowing *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Heartburn from spicy, fatty, citrus foods or beverages such as coffee or alcohol *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Heartburn is worse when leaning forward or lying down *
- [ ] Never
- [ ] Sometimes
- [x] Regularly
- [ ] Always

Stomach pain, aching or burning sensation one to four hours after consuming food *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Very dark to almost black stools *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Vomiting with blood in it *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

Digestive System - Small Intestine & Pancreas

Abdominal spasms or cramps with pain *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Alternation of diarrhoea and constipation *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Constipation that require strain on passing and is hard, dry or small *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Difficulty in gaining weight *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Difficulty in losing weight *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Dry skin and coarse or brittle hair *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Flatulence *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Greasy and smelly stool that stick to the bowl of the toilet *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Nausea with or without vomiting *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Sensitivity to certain foods that trigger abdominal symptoms *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Undigested food in stool *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

Digestive System - Large Intestine

Alleviation from pain after evacuation of stool or flatulence *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Bright red or fresh blood in stool on evacuation *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Burning sensation of the rectal area *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Certain foods that trigger abdominal discomfort *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Dark red or occult blood in stool on evacuation *

Never Sometimes Regularly Always

Diarrhoea that manifests with very loose, watery, frequent and urgency to go to the toilet *
Never Sometimes Regularly Always

Increased bloating and flatulence *
Never Sometimes Regularly Always

Increased stress that trigger abdominal discomfort or spasms *
Never Sometimes Regularly Always

Itching sensation in the rectal area *
Never Sometimes Regularly Always

Mucous discharge in stool *
Never Sometimes Regularly Always

Pain during evacuation in rectal area *
Never Sometimes Regularly Always

Spasms, cramping or pain in lower abdominal area *
Never Sometimes Regularly Always

Very narrow or almost stringy type stool *
Never Sometimes Regularly Always

Do you have any comments in regard to the above questions?

Digestive Health - Liver & Gallbladder

Chronically fatigued or weakness *
Never Sometimes Regularly Always

Clay or yellow coloured stools *
Never Sometimes Regularly Always

Consuming fatty foods causes nausea or indigestion *
Never Sometimes Regularly Always

Dark and concentrated colour of urine along with yellowing in the sclera of the eyes *
Never Sometimes Regularly Always

Diagnosed with Fatty Liver Disease *
Never Sometimes Regularly Always

Dry and flaky skin *
Never Sometimes Regularly Always

Easily bruises *
Never Sometimes Regularly Always

Experiencing pain below the ribs on the right side *
Never Sometimes Regularly Always

Gets nauseas really easy from food or certain smells *
Never Sometimes Regularly Always

Gums bleed easily *
Never Sometimes Regularly Always

Hair loss or thinning of hair *
Never Sometimes Regularly Always

Itchy skin without rash or explanation *
Never Sometimes Regularly Always

Loss of appetite *
Never Sometimes Regularly Always

Red skin (especially on palms) *
Never Sometimes Regularly Always

Sensitivity to smells (perfume, petrol, etc.) *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Water retention or oedema *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

Digestive Health - Previous Diagnosis's

Please tick YES if you have ever been diagnosed with any of the following:

Anal fissures *
- (●) NO
- ( ) YES

Coeliac Disease *
- (●) NO
- ( ) YES

Crohn's Disease *
- (●) NO
- ( ) YES

Diverticulitis *
- (●) NO
- ( ) YES

Fatty Liver Disease *
- (●) NO
- ( ) YES

Gallstones *
- (●) NO
- ( ) YES

GERD - Gastroesophageal Reflux Disease *
- ( ) NO
- (●) YES

Inflammatory Bowel Disorder *
- (●) NO
- ( ) YES

Irritable Bowel Syndrome *
- ( ) NO
- (●) YES

Peptic Ulcer Disease *
- ( ) NO
- (●) YES

Ulcerative Colitis *
- (●) NO
- ( ) YES

Do you have any comments in regard to the above questions?

Stool Type

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Please choose the Type that is the closest to what you have experienced in the last 2 weeks *

- ○ Type 1
- ○ Type 2
- ○ Type 3
- ○ Type 4
- ◉ Type 5
- ○ Type 6
- ○ Type 7

Food Recall Diary

Breakfast

Eggs
Sauerkraut

Please provide details of a typical breakfast

Morning tea

Please provide details of a typical morning tea

Lunch

Chicken cheese salad

Please provide details of a typical lunch

Afternoon Tea

Please provide details of a typical afternoon tea

Dinner

Wine
Sometimes spaghetti or a meal

Please provide details of a typical dinner

Additional snacks

Please list any additional snacks

Liquids consumed

Water
Coffee

Please provide details of typical liquids consumed

Endocrine System - Hypothyroidism

Difficulty in losing weight and gaining weight increasingly *
- ○ Never ○ Sometimes ◉ Regularly ○ Always

Dry skin or hair *
- ○ Never ○ Sometimes ◉ Regularly ○ Always

Facial swelling, retaining water in hands or feet *
- ○ Never ◉ Sometimes ○ Regularly ○ Always

Feeling of fatigue and lacking energy *
- ○ Never ○ Sometimes ○ Regularly ◉ Always

Fertility concerns or issues *
- ◉ Never ○ Sometimes ○ Regularly ○ Always

Intolerable to cold weather or feeling cold easily *
- ◉ Never ○ Sometimes ○ Regularly ○ Always

Issues with heavy menstrual periods *
- ○ Never ◉ Sometimes ○ Regularly ○ Always

Low or no libido *
- ○ Never ○ Sometimes ○ Regularly ◉ Always

Low mood and irritability *
- ○ Never ○ Sometimes ○ Regularly ◉ Always

Poor memory and difficulty with concentration *
- ○ Never ○ Sometimes ◉ Regularly ○ Always

Reduced appetite *
- ◉ Never ○ Sometimes ○ Regularly ○ Always

Swelling or feeling of tightness in front of neck *
- ◉ Never ○ Sometimes ○ Regularly ○ Always

Do you have any comments in regard to the above questions?

Endocrine System - Hyperthyroid

Diarrhoea *
- ○ Never ○ Sometimes ◉ Regularly ○ Always

Fatigue with weakness in limbs *
- ○ Never ○ Sometimes ◉ Regularly ○ Always

Feeling hot easily and intolerable to heat *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Feeling of being shaky *
- ○ Never ○ Sometimes ● Regularly
- ○ Always

Issues with light and infrequent menstrual periods *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Low to no libido *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Nervous, stressed, irritable and restless *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Palpitations *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Struggling to fall asleep or complete insomnia *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Swelling or feeling of constriction in front of neck *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Visual disturbances and poor sight *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Weight loss without intention *
- ○ Never ○ Sometimes ● Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Endocrine System - Stress, fatigue and adrenal function

Changes in appetite *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Difficulty falling asleep and maintaining sleep *
- ○ Never ○ Sometimes ● Regularly
- ○ Always

Difficulty keeping awake and focussed during the day *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Difficulty rising in the morning and a feel of no refreshing *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Easily fatigued *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Experiencing difficulty in maintaining concentration and retaining memory *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Experience a sense of overwhelm *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Experience low mood with alternating mood swings *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Experiencing nausea with dizziness *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Experiencing oversensitivity or irritability *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Experiencing stress, nervousness and anxiety or overly tense without ability to relax *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Heart palpitations or tightness in chest with pain *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Require stimulants such as coffee, tea, nicotine or sugary foods *

○ Never ○ Sometimes ○ Regularly ◉ Always

Do you have any comments in regard to the above questions?

Energy Scale

Please indicate what best describes your energy level in general:

○ 1 ○ 2 ○ 3 ◉ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Rating your energy level according to 1 being extremely fatigued and 10 being jumping out of bed in the morning ready to take on life ;-)

Immune System - General

Bleeding gums, swollen lips or tongue *
○ Never ◉ Sometimes ○ Regularly
○ Always

Chronically fatigued *
○ Never ○ Sometimes ◉ Regularly
○ Always

Cold sores on lips or in oral area *
◉ Never ○ Sometimes ○ Regularly
○ Always

Cough that produces discharge *
○ Never ○ Sometimes ◉ Regularly
○ Always

Ears continually have discharge *
○ Never ◉ Sometimes ○ Regularly
○ Always

Excessive hair loss *
○ Never ◉ Sometimes ○ Regularly
○ Always

Excessive night sweats *
○ Never ○ Sometimes ○ Regularly
◉ Always

Extended recovery time after infection *
○ Never ◉ Sometimes ○ Regularly
○ Always

Fevers with unexplained hovering *
◉ Never ○ Sometimes ○ Regularly
○ Always

Frequent colds or flus *
○ Never ◉ Sometimes ○ Regularly
○ Always

Inability to build a proper fever *
○ Never ◉ Sometimes ○ Regularly
○ Always

Nasal congestion and discharge *
○ Never ◉ Sometimes ○ Regularly
○ Always

Regular infections such as urinary tract and skin *
○ Never ◉ Sometimes ○ Regularly
○ Always

Slow wound healing *
○ Never ○ Sometimes ◉ Regularly
○ Always

Sore throat on a regular basis *
○ Never ○ Sometimes ◉ Regularly
○ Always

Swollen lymph nodes in neck, armpit or groin *
○ Never ◉ Sometimes ○ Regularly
○ Always

Do you have any comments in regard to the above questions?

Immune System - Allergies

Certain food triggers that worsen symptoms *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Dark circles under the eyes *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

General itching in areas of the eyes, ears, throat, skin or nose *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Headaches or migraines *
- ○ Never
- ○ Sometimes
- ◉ Regularly
- ○ Always

Light sensitivity on skin or eyes *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Skin rashes or eczema *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

Sneezing, wheezing or coughing *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

Swelling of body parts, eyes, lips or face *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Watery discharge from eyes or nose *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Cardiovascular System - Blood Pressure Maintenance

Blurred vision *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Family history of elevated blood pressure or Cardiovascular disease *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

Flushed or redness in the face *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Headaches *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

History of elevated blood pressure (greater than 140/80) *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Nosebleeds *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Ringing in ears *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Cardiovascular System - Red Blood Cell Maintenance

Challenged concentration and low memory *
- ○ Never ○ Sometimes ◉ Regularly
- ○ Always

Easily bruises or bleeds and low clotting when you have a wound *
- ○ Never ○ Sometimes ◉ Regularly
- ○ Always

Extended recovery period needed after exercise *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Feeling of faintness with ringing in ears or spots before eyes *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Increased levels of fatigue *
- ○ Never ○ Sometimes ◉ Regularly
- ○ Always

Low exercise tolerance with shortness of breath *
- ○ Never ○ Sometimes ◉ Regularly
- ○ Always

Pale eyelids, gums and nails *
- ○ Never ○ Sometimes ◉ Regularly
- ○ Always

Red tongue with sensitivity *
- ◉ Never ○ Sometimes ○ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Cardiovascular System - Heart Health

Diagnosis of Cardiovascular Disease *
- ◉ Never ○ Sometimes ○ Regularly
- ○ Always

Easily fatigued and a poor tolerance to exercise *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Excessive sweating with paleness, tight chest or unusual digestion with possible nausea *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Experience a dry cough with wheezing *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Experience dizziness or feeling faint *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Experience heart palpitations *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Experience heartburn, nausea, vomiting with pain and heavy sensation that radiates to the neck, jaw, left shoulder or arm *
- ◉ Never ○ Sometimes ○ Regularly
- ○ Always

Pathology history of high triglycerides or blood cholesterol *
- ◉ Never ○ Sometimes ○ Regularly
- ○ Always

Prominent veins in the neck *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Shortness of breath with effort and force *
- ○ Never ○ Sometimes ◉ Regularly
- ○ Always

Tight and heavy chest with pain *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Water retention and swelling of feet, ankles or legs *
- ○ Never ◉ Sometimes ○ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Cardiovascular System - Circulation

Fainting or falling without known cause *
- ○ Never ○ Sometimes ○ Regularly
- ○ Always

Muscle aches and pain in calves or thighs *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Periods of loss of whole part of vision, double vision, impaired co-ordination and areas of numbness *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Periods of impaired speech, swallowing and occasional loss of understanding for reading or speaking *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Slow circulation with coldness or numbness in extremities, pins and needles sensation in hands, feet, fingers or toes *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Slow concentration and low memory *
- ○ Never ○ Sometimes ● Regularly
- ○ Always

Ulcers on legs or feet *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Varicose veins *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Metabolic Health / Glucose Tolerance

An increased appetite or thirst *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Excessive sweating *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Faintness or dizziness when standing up from a sitting position *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Faintness or light-headedness *
- ○ Never ● Sometimes ○ Regularly
- ○ Always

Fatigue *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Frequent and excessive urination *
- ○ Never ○ Sometimes ● Regularly
- ○ Always

Headaches *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Increased infections and reoccurrence thereof, such as bladder or skin *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Irritability and restlessness *
- ○ Never ○ Sometimes ○ Regularly
- ● Always

Palpitations or increased sweating *
- ○ Never ○ Sometimes ● Regularly
- ○ Always

Poor memory, concentration and confusion *
- ○ Never ○ Sometimes ● Regularly
- ○ Always

Previously diagnosed with Diabetes I or II *
- ● Never ○ Sometimes ○ Regularly
- ○ Always

Slow wound healing *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Vision issues such as blurry and failing eyesight *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Weakness, tiredness or shaky *
- ○ Never
- ○ Sometimes
- ◉ Regularly
- ○ Always

Weight gain without increased food consumption *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Weight loss that is unintentional *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Genito-urinary System - Kidney & Bladder

Blood in urine *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Burning sensation during urination *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Concentrated, cloudy and dark urine with or without strong odour *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Excessive urination *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Extreme one-sided pain in lower back or groin associated with agitation *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Grey'ish tone to skin *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

History of kidney stones *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Incontinence *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Infrequent urination *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Pain in the lower back *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Urgency of urination *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Urination during night - excessively *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Water retention in various parts of the body *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Female Reproductive System - Pre-menstrual symptoms

Pre-menstrual symptoms experienced 3-14 days prior to menstruation and has been observed in the last 3 months:

Abdominal bloating *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Back pain *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Change in bowel movements *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

Clumsiness *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Feeling of anger, anxiousness or irritability *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

Feeling of depression, teariness or sensitivity *
- ○ Never
- ○ Sometimes
- ○ Regularly
- ◉ Always

Increased cravings for certain foods *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Increased headaches or migraines *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Insomnia *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Overwhelming aggressiveness or suicidal thoughts *
- ○ Never
- ○ Sometimes
- ◉ Regularly
- ○ Always

Retention of fluid or weight gain *
- ○ Never
- ○ Sometimes
- ◉ Regularly
- ○ Always

Tenderness of breasts with swelling or lumps *
- ○ Never
- ○ Sometimes
- ◉ Regularly
- ○ Always

Do you have any comments in regard to the above questions?

Female Reproductive System - Menstrual irregularities

Amenorrhoea (absence of flow more than 5 months other than being pregnant) *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Bleeding or spotting between periods *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Increased blood clots and increased size of clots *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Increased number of days of bleeding (more than 7 days) *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Increased pain during periods *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Irregular intervals between periods *
- ○ Never
- ◉ Sometimes
- ○ Regularly
- ○ Always

Miscarriage or early termination of pregnancy *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Odorous vaginal discharge *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Painful intercourse *
- ◉ Never
- ○ Sometimes
- ○ Regularly
- ○ Always

Painful periods in lower back or lower abdominal area *
- ○ Never
- ◉ Sometimes
- ○ Regularly

Always

Period cycles greater than 32 days *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Period cycles less than 24 days *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Rectal or pelvic pressure during time of menstruation *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Skin conditions such as acne or oily skin *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Very heavy blood flow or flooding *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Very light blood flow *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

Female Reproductive System - Peri-menopausal & Menopausal Symptoms

Breast reduction and sagging *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Decline in concentration, memory or confusion *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Diminished libido *
- ( ) Never
- ( ) Sometimes
- ( ) Regularly
- (•) Always

Excessive sweating, especially at night *
- ( ) Never
- ( ) Sometimes
- ( ) Regularly
- (•) Always

Experiencing drying of hair, skin or vaginal areas *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Hair loss and thinning with decrease in hairline *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Hot flushes in head, neck or chest *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Increased hair growth on chin or upper lip *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Insomnia with challenged onset and maintenance of sleep *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Menstrual cycle that has changed in regularity or flow *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Moody, irritable, anxious, depressed, nervous or a sense of overwhelm *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Painful intercourse due to dryness *
- (•) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

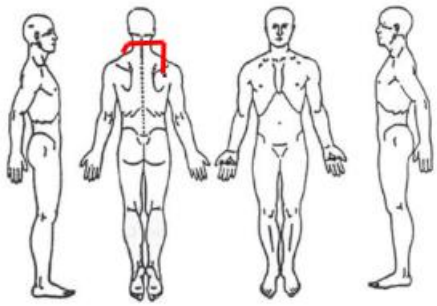
Do you have any comments in regard to the above questions?

Musculoskeletal - Pain

Are you currently experiencing any musculoskeletal related pain? *

- (•) Yes
- ( ) No

Please circle where you are currently experiencing pain



Clear drawing

Please circle with your finger or mouse cursor the approximate area that you are experiencing pain or discomfort.

Pain Scale

( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 (•) 7 ( ) 8 ( ) 9 ( ) 10

Please indicate what your current level of pain is ranging from 1 that is almost nothing at all and 10 being in excruciating pain.

Musculoskeletal System - Bone Health

Bone fracture without explanation - not accident related *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Bone tenderness, aches or pain *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Difficulty walking or walking with a limp *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Hip pain or low back pain *

( ) Never (•) Sometimes ( ) Regularly ( ) Always

Hump at base of neck *

( ) Never ( ) Sometimes (•) Regularly ( ) Always

Localised bone pain *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Lordosis diagnosis *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Loss of hearing with headaches and tinnitus *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Loss of height and appearing shorter *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Osteoarthritis diagnosis *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Osteoporosis diagnosis *

(•) Never ( ) Sometimes ( ) Regularly ( ) Always

Painful shins after or during exercise *

( ) Never (•) Sometimes ( ) Regularly ( ) Always

Scoliosis diagnosis *

Swelling or deformity of bone *

- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Do you have any comments in regard to the above questions?

Musculoskeletal System - Muscles

Cramps or spasms *
- [ ] Never
- [ ] Sometimes
- [x] Regularly
- [ ] Always

Muscle pain, aches, stiffness or tension *
- [ ] Never
- [ ] Sometimes
- [x] Regularly
- [ ] Always

Muscle weakness or loss *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Restless legs *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Twitching of eye lids or lips *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Do you have any comments in regard to the above questions?

Musculoskeletal System - Connective Tissue

Challenged when standing up from a sitting position *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Joints that are tender, stiff, swollen or inflamed *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Joints that creak when you move or stand up *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Knobbly joints *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Limping when walking *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

More than one joint that has pain *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Muscle wastage *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Numbness, prickling or tingling sensation in the fingers, arms, shoulders or neck *
- [ ] Never
- [ ] Sometimes
- [ ] Regularly
- [x] Always

Painful with dry eyes or dry mouth *
- [ ] Never
- [x] Sometimes
- [ ] Regularly
- [ ] Always

Painless lumps forming on toes, knees or elbows *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Restriction in motion and range *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Restriction in performing function or mobility *
- [x] Never
- [ ] Sometimes
- [ ] Regularly
- [ ] Always

Shooting or tingling pain down the back of leg *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

When exercising, injury, sprain and strain occurs easily *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

Nervous System - Neurological Symptoms

Challenged with focussing, concentration and retaining memory *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Changes in senses: taste, smell, touch, hearing and seeing *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Changes in speech - slower and slurring *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Experiencing headaches *
- ( ) Never
- ( ) Sometimes
- ( ) Regularly
- (●) Always

Eyelids that droop *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Fatigues easily *
- ( ) Never
- ( ) Sometimes
- (●) Regularly
- ( ) Always

Feeling of clumsiness *
- ( ) Never
- ( ) Sometimes
- (●) Regularly
- ( ) Always

Hands shaking *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Incontinence *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Light-headedness and fainting *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Issues with eye-hand-coordination *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Not feeling stable when standing *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Pins and needles, tingling or numbness in limbs *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Seizures or convulsions *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Tinnitus - ringing in ears *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Weakness in limbs *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

Nervous System - Cognitive Function

Challenged in ability to relax *
- ( ) Never
- ( ) Sometimes
- ( ) Regularly
- (•) Always

Experience difficulty to retain memory *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Experience food allergies *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Experience a short concentration span *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Experiencing confusion or brain fog *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Inability to sit still and need to fidget *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

History of Stressful Events in the last 24 months

Death of a family member or close friend *
- (•) No
- ( ) Yes

Divorce or Separation *
- (•) No
- ( ) Yes

Financial challenges *
- ( ) No
- (•) Yes

Loss of work *
- ( ) No
- (•) Yes

Marital challenges *
- ( ) No
- (•) Yes

Moving house *
- ( ) No
- (•) Yes

Personal injury or illness *
- ( ) No
- (•) Yes

Retirement *
- (•) No
- ( ) Yes

Starting a new job *
- ( ) No
- (•) Yes

Violations of the law *
- (•) No
- ( ) Yes

Do you have any comments in regard to the above questions?

Insomnia Relevant Assessment

Can't switch off, overthinking and worrying *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Consume caffeine after 2pm or chocolate close to bedtime *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Consume food after 7pm *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Experience ongoing discomfort or pain *
- ( ) Never
- ( ) Sometimes
- (•) Regularly
- ( ) Always

Have a poor maintenance of sleep *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Have a poor onset of sleep *
- ( ) Never
- (•) Sometimes
- ( ) Regularly
- ( ) Always

Stressful environment in work or personal life *
○ Never ○ Sometimes ○ Regularly ◉ Always

Do you have any comments in regard to the above questions?

Respiratory System

Blood in sputum (phlegm or spit) when coughing *
◉ Never ○ Sometimes ○ Regularly
○ Always

Chest pain when breathing *
◉ Never ○ Sometimes ○ Regularly
○ Always

Cold's or flu's has a tendency to go the chest really quickly *
○ Never ◉ Sometimes ○ Regularly
○ Always

Frothy sputum *
◉ Never ○ Sometimes ○ Regularly
○ Always

Offensive breath or foul smelling sputum *
◉ Never ○ Sometimes ○ Regularly
○ Always

Persistent cough - dry or moist *
○ Never ○ Sometimes ◉ Regularly
○ Always

Shallow breathing - not filling the lung to capacity *
○ Never ◉ Sometimes ○ Regularly
○ Always

Short of breath without strenuous exercise *
◉ Never ○ Sometimes ○ Regularly
○ Always

Snoring loudly *
○ Never ○ Sometimes ○ Regularly
◉ Always

Sputum are thick yellow, green or brown *
○ Never ○ Sometimes ○ Regularly
◉ Always

Wheezing or purring when breathing *
○ Never ◉ Sometimes ○ Regularly ○ Always

Do you have any comments in regard to the above questions?

Integumentary System: Skin, Hair & Nails

Do you experience any of the following?

Acne *
◉ Never ○ Sometimes ○ Regularly
○ Always

Dandruff *
○ Never ◉ Sometimes ○ Regularly
○ Always

Eczema / Dermatitis *
○ Never ○ Sometimes ○ Regularly
◉ Always

Moles that have changed in size or colour *
◉ Never ○ Sometimes ○ Regularly
○ Always

Nails - pitted *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Nails - thickened *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Nails - weak or brittle *
- ( ) Never
- (●) Sometimes
- ( ) Regularly
- ( ) Always

Nails - discolouring *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Pigmentation - decreased *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Pigmentation - increased *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Psoriasis *
- ( ) Never
- ( ) Sometimes
- ( ) Regularly
- (●) Always

Rashes - unexplained *
- ( ) Never
- ( ) Sometimes
- ( ) Regularly
- (●) Always

Redness, discoloured path of skin OR itch without explanation *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Warts *
- (●) Never
- ( ) Sometimes
- ( ) Regularly
- ( ) Always

Do you have any comments in regard to the above questions?

Detoxification - Sensitivities

Do you experience an ...

Allergy or sensitivity to sodium benzoate or potassium benzoate *
- (●) No
- ( ) Yes

Allergy or sensitivity to Tyramine (found in red wine, cheese, bananas, chocolate)? *
- (●) No
- ( ) Yes

Allergy or sensitivity to caffeine *
- (●) No
- ( ) Yes

Allergy or sensitivity to chemicals that include perfumes, exhaust fumes, smoke or strong odours? *
- (●) No
- ( ) Yes

Allergy or sensitivity to alcohol (even in small amounts) *
- (●) No
- ( ) Yes

Do you have a history of exposure to chemicals that include herbicides, insecticides, pesticides, organic solvents or mould? *
- (●) No
- ( ) Yes

How much glasses of alcohol do you consume per week? *
- ( ) 0
- ( ) 1-7
- ( ) 8-14
- (●) 15+

How much caffeine beverages do you consume per day? *
- ( ) 0
- ( ) 1-2
- ( ) 3-4
- (●) 5+

Do you use any recreational drugs? *

- (•) Yes
- ( ) No
- ( ) I'd rather not say

What is your blood type?

B+

Please type unknown if you are not sure.

Please check all that apply to your immediate family:

- [x] Asthma / Lung disorders
- [x] Cancer
- [ ] Cardiovascular Disease
- [ ] Diabetes 1 or 2
- [x] History of Back Pain
- [x] Hypertension
- [x] Kidney Disorders
- [ ] Psychiatric Disorders
- [ ] Seizure Disorder
- [ ] Stroke

Thank you for taking the time to invest in your health outcome by completing this questionnaire!

Declaration

By signing this form you agree that everthing you answered is true and correct and will be used in discussion to advise you of dietary and lifestyle changes as well as prescribing herbal/nutritional supplements.

You also agree to the 48 hour cancellation / reschedule policy as set out by this Clinic. Any cancellations or rescheduling needs to be done more than 48 hours before the consultation to avoid any penalties in fees. You will receive a reminder 72 hours before the consultation.

Please sign here *

Date *

24/04/2023