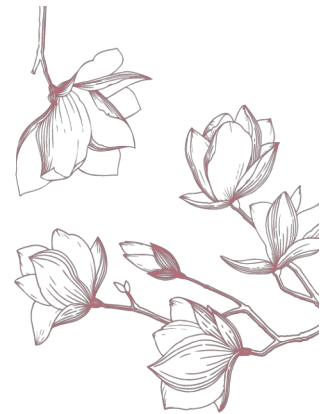




cindy biccard
naturopathic medicine



Registration & 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 your privacy and would not want you to feel uncomfortable in any way.

First Name *

Juanita

Middle Name: *

none

Last Name *

Struwig

Please select your biological gender *

- ☐ Male
☒ Female

Date of Birth *

23/09/1978

Phone Number *

0431065492

Email Address *

juanitastruwig@gmail.com

Address *

22 Sonata Drive, Warner QLD, Australia

Occupation *

Bookkeeper and accountant

Emergency Contact Name *

Jacques

Relationship to Patient *

Husband

Phone Number of Emergency Contact *

0428286885

Medical History

Recent blood tests

Browse

If you have any recent blood tests (within the last 6 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:

Tonsils (1982), Laparoscopy (2008), Cesarean (2010)

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

Have you received the COVID-19 vaccination? *

☒ Yes ☐ No

Do you have any known allergies? *

☒ Yes ☐ No

Please list the allergy/ies and consequence

Iodine contrast - a severe reaction

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

☒ Yes ☐ No

Medication / Supplements

Multi vitamins
Fusion memory and stress and anxiety

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

☐ Yes ☒ No

Anti-diabetic / Insulin

☐ Yes ☒ No

Anti-Histamines

☐ Yes ☒ No

Anti-Inflammatories (Aspirin, Nurofen)

☒ Yes ☐ No

Anti-psychotics

☐ Yes ☒ No

Antibiotics

☐ Yes ☒ No

Antidepressants

☐ Yes ☒ No

Asthma preventer / inhaler

☐ Yes ☒ No

Chemotherapy

☐ Yes ☒ No

Heart medication

☐ Yes ☒ No

High blood pressure medication

☐ Yes ☒ No

Hormone modulators / Oral contraceptive pill

☐ Yes ☒ No

Paracetamol

☒ Yes ☐ No

Radiation therapy

☐ Yes ☒ No

Sleeping medications / Relaxants

☐ Yes ☒ No

Steroids

☐ Yes ☒ No

Thyroid medication

☐ Yes ☒ No

Are you currently smoking? *

☐ Yes

☒ No

Are you satisfied with your current weight? *

☐ Yes

☒ No

What is your current weight? *

59kg

What is your height in cm? *

1.63

What is your ideal weight? *

57kg

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

Frequent urination at night and bladder irritation
Due to the above a lack of enough proper sleep

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. 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 ☒ Sometimes ☐ Regularly
☐ Always

Excessive burping *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Indigestion *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Nausea *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Alleviation from heartburn using antacids, carbonate, beverages, milk, or cream *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Difficulty or discomfort when swallowing *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Heartburn is worse when leaning forward or lying down *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Very dark to almost black stools *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Bloating during or directly after consuming food *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

History of low iron levels or anaemia *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Loss of appetite *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Sensation of food stagnating after eating *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Constipation *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Heartburn from spicy, fatty, citrus foods or beverages such as coffee or alcohol *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Stomach pain, aching or burning sensation one to four hours after consuming food *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Vomiting with blood in it *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Digestive System - Small Intestine & Pancreas

Abdominal spasms or cramps with pain *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Constipation that require strain on passing and is hard, dry or small *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Difficulty in losing weight *

- ☐ Never ☒ Sometimes ☐ Regularly

Alternation of diarrhoea and constipation *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Difficulty in gaining weight *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Dry skin and coarse or brittle hair *

- ☐ Never ☐ Sometimes ☒ Regularly

☐ Always

Flatulence *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nausea with or without vomiting *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Undigested food in stool *

☒ Never ☐ Sometimes ☐ Regularly ☐ Always

☐ Always

Greasy and smelly stool that stick to the bowl of the toilet *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Sensitivity to certain foods that trigger abdominal symptoms *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Digestive System - Large Intestine

Alleviation from pain after evacuation of stool or flatulence *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Burning sensation of the rectal area *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Dark red or occult blood in stool on evacuation *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Increased bloating and flatulence *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Itching sensation in the rectal area *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Pain during evacuation in rectal area *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Very narrow or almost stringy type stool *

☒ Never ☐ Sometimes ☐ Regularly ☐ Always

Bright red or fresh blood in stool on evacuation *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Certain foods that trigger abdominal discomfort *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Diarrhoea that manifests with very loose, watery, frequent and urgency to go to the toilet *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Increased stress that trigger abdominal discomfort or spasms *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Mucous discharge in stool *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Spasms, cramping or pain in lower abdominal area *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Digestive Health - Liver & Gallbladder

Chronically fatigued or weakness *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Consuming fatty foods causes nausea or indigestion *

Clay or yellow coloured stools *

☒ 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

Easily bruises *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Gets nauseas really easy from food or certain smells *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Hair loss or thinning of hair *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

Loss of appetite *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Sensitivity to smells (perfume, petrol, etc.) *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Dry and flaky skin *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Experiencing pain below the ribs on the right side *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Gums bleed easily *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Itchy skin without rash or explanation *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Red skin (especially on palms) *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Water retention or oedema *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Digestive Health - Previous Diagnosis's

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

Anal fissures *

☒ NO ☐ YES

Crohn's Disease *

☒ NO ☐ YES

Gallstones *

☒ NO ☐ YES

Inflammatory Bowel Disorder *

☒ NO ☐ YES

Peptic Ulcer Disease *

☒ NO ☐ YES

Coeliac Disease *

☒ NO ☐ YES

Diverticulitis *

☒ NO ☐ YES

GERD - Gastroesophageal Reflux Disease *

☒ NO ☐ YES

Irritable Bowel Syndrome *

☒ NO ☐ YES

Ulcerative Colitis *

☒ NO ☐ YES

Endocrine System - Hypothyroidism

Difficulty in losing weight and gaining weight increasingly *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Facial swelling, retaining water in hands or feet *

☐ Never ☒ Sometimes ☐ Regularly

Dry skin or hair *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

Feeling of fatigue and lacking energy *

☐ Never ☒ Sometimes ☐ Regularly

☐ Always

Fertility concerns or issues *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

Issues with heavy menstrual periods *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Low mood and irritability *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Reduced appetite *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

☐ Always

Intolerable to cold weather or feeling cold easily *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Low or no libido *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Poor memory and difficulty with concentration *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Swelling or feeling of tightness in front of neck *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Endocrine System - Hyperthyroid

Diarrhoea *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Feeling hot easily and intolerable to heat *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Issues with light and infrequent menstrual periods *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nervous, stressed, irritable and restless *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Struggling to fall asleep or complete insomnia *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Visual disturbances and poor sight *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Fatigue with weakness in limbs *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Feeling of being shaky *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Low to no libido *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Palpitations *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Swelling or feeling of constriction in front of neck *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Weight loss without intention *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Endocrine System - Stress, fatigue and adrenal function

Changes in appetite *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Difficulty keeping awake and focussed during the day *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Difficulty falling asleep and maintaining sleep *

☐ 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

Experience a sense of overwhelm *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experiencing nausea with dizziness *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Experiencing stress, nervousness and anxiety or overly tense without ability to relax *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

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

☐ Never ☒ Sometimes ☐ Regularly ☐ Always

Experiencing difficulty in maintaining concentration and retaining memory *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experience low mood with alternating mood swings *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experiencing oversensitivity or irritability *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Heart palpitations or tightness in chest with pain *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Immune System - General

Bleeding gums, swollen lips or tongue *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Cold sores on lips or in oral area *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Ears continually have discharge *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Excessive night sweats *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Fevers with unexplained hovering *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Inability to build a proper fever *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Regular infections such as urinary tract and skin *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Sore throat on a regular basis *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Chronically fatigued *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Cough that produces discharge *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Excessive hair loss *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

Extended recovery time after infection *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Frequent colds or flus *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Nasal congestion and discharge *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Slow wound healing *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Swollen lymph nodes in neck, armpit or groin *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Immune System - Allergies

Certain food triggers that worsen symptoms *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

General itching in areas of the eyes, ears, throat, skin or nose *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Light sensitivity on skin or eyes *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Sneezing, wheezing or coughing *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Watery discharge from eyes or nose *

- ☒ Never ☐ Sometimes ☐ Regularly ☐ Always

Dark circles under the eyes *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Headaches or migraines *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Skin rashes or eczema *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Swelling of body parts, eyes, lips or face *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Cardiovascular System - Blood Pressure Maintenance

Blurred vision *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Flushed or redness in the face *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

History of elevated blood pressure (greater than 140/80) *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Ringing in ears *

- ☒ Never ☐ Sometimes ☐ Regularly ☐ Always

Family history of elevated blood pressure or Cardiovascular disease *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Headaches *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Nosebleeds *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Cardiovascular System - Red Blood Cell Maintenance

Challenged concentration and low memory *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Extended recovery period needed after exercise *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Increased levels of fatigue *

Easily bruises or bleeds and low clotting when you have a wound *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Feeling of faintness with ringing in ears or spots before eyes *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Low exercise tolerance with shortness of breath *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Pale eyelids, gums and nails *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Red tongue with sensitivity *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Cardiovascular System - Heart Health

Diagnosis of Cardiovascular Disease *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Excessive sweating with paleness, tight chest or unusual digestion with possible nausea *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Experience dizziness or feeling faint *

☒ 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

Prominent veins in the neck *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Tight and heavy chest with pain *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Easily fatigued and a poor tolerance to exercise *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experience a dry cough with wheezing *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Experience heart palpitations *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Pathology history of high triglycerides or blood cholesterol *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Shortness of breath with effort and force *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Water retention and swelling of feet, ankles or legs *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Cardiovascular System - Circulation

Fainting or falling without known cause *

☒ 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

Slow circulation with coldness or numbness in extremities, pins and needles sensation in hands, feet, fingers or toes *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Ulcers on legs or feet *

Muscle aches and pain in calves or thighs *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Periods of impaired speech, swallowing and occasional loss of understanding for reading or speaking *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Slow concentration and low memory *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Varicose veins *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Metabolic Health / Glucose Tolerance

An increased appetite or thirst *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Faintness or dizziness when standing up from a sitting position *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Fatigue *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Headaches *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Irritability and restlessness *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Poor memory, concentration and confusion *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Slow wound healing *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Weakness, tiredness or shaky *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Weight loss that is unintentional *

☒ Never ☐ Sometimes ☐ Regularly ☐ Always

Excessive sweating *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Faintness or light-headedness *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Frequent and excessive urination *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

Increased infections and reoccurrence thereof, such as bladder or skin *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Palpitations or increased sweating *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Previously diagnosed with Diabetes I or II *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Vision issues such as blurry and failing eyesight *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Weight gain without increased food consumption *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Genito-urinary System - Kidney & Bladder

Blood in urine *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Concentrated, cloudy and dark urine with or without strong odour *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Burning sensation during urination *

☐ 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

History of kidney stones *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Infrequent urination *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Urgency of urination *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

Water retention in various parts of the body *

☒ Never ☐ Sometimes ☐ Regularly ☐ Always

Grey'ish tone to skin *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Incontinence *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Pain in the lower back *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Urination during night - excessively *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

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

Change in bowel movements *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Feeling of anger, anxiousness or irritability *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Increased cravings for certain foods *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Insomnia *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Retention of fluid or weight gain *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Back pain *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Clumsiness *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Feeling of depression, teariness or sensitivity *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Increased headaches or migraines *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Overwhelming aggressiveness or suicidal thoughts *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Tenderness of breasts with swelling or lumps *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Female Reproductive System - Menstrual irregularities

Amenorrhoea (absence of flow more than 5 months other than being pregnant) *

☒ Never ☐ Sometimes ☐ Regularly

Bleeding or spotting between periods *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

☐ Always

Increased blood clots and increased size of clots *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Increased pain during periods *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Miscarriage or early termination of pregnancy *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Painful intercourse *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Period cycles greater than 32 days *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Rectal or pelvic pressure during time of menstruation *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Very heavy blood flow or flooding *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Increased number of days of bleeding (more than 7 days) *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Irregular intervals between periods *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Odorous vaginal discharge *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Painful periods in lower back or lower abdominal area *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Period cycles less than 24 days *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Skin conditions such as acne or oily skin *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Very light blood flow *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Female Reproductive System - Peri-menopausal & Menopausal Symptoms

Breast reduction and sagging *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Diminished libido *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experiencing drying of hair, skin or vaginal areas *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Hot flushes in head, neck or chest *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Insomnia with challenged onset and maintenance of sleep *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Decline in concentration, memory or confusion *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Excessive sweating, especially at night *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Hair loss and thinning with decrease in hairline *

☐ Never ☐ Sometimes ☒ Regularly
☐ Always

Increased hair growth on chin or upper lip *

☐ 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

Musculoskeletal System - Bone Health

Bone fracture without explanation - not accident related *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Difficulty walking or walking with a limp *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Hump at base of neck *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Lordosis diagnosis *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Loss of height and appearing shorter *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Osteoporosis diagnosis *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Scoliosis diagnosis *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Bone tenderness, aches or pain *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Hip pain or low back pain *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Localised bone pain *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Loss of hearing with headaches and tinnitus *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Osteoarthritis diagnosis *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Painful shins after or during exercise *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Swelling or deformity of bone *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Musculoskeletal System - Muscles

Cramps or spasms *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Muscle weakness or loss *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Twitching of eye lids or lips *

- ☒ Never ☐ Sometimes ☐ Regularly ☐ Always

Muscle pain, aches, stiffness or tension *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Restless legs *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Musculoskeletal System - Connective Tissue

Challenged when standing up from a sitting position *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Joints that creak when you move or stand up *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Limping when walking *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Muscle wastage *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Painful with dry eyes or dry mouth *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Restriction in motion and range *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Shooting or tingling pain down the back of leg *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Joints that are tender, stiff, swollen or inflamed *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Knobbly joints *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

More than one joint that has pain *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Numbness, prickling or tingling sensation in the fingers, arms, shoulders or neck *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Painless lumps forming on toes, knees or elbows *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Restriction in performing function or mobility *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

When exercising, injury, sprain and strain occurs easily *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nervous System - Neurological Symptoms

Challenged with focussing, concentration and retaining memory *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Changes in speech - slower and slurring *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Eyelids that droop *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Feeling of clumsiness *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Incontinence *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Issues with eye-hand-coordination *

Changes in senses: taste, smell, touch, hearing and seeing *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Experiencing headaches *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Fatigues easily *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Hands shaking *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Light-headedness and fainting *

- ☒ 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

Tinnitus - ringing in ears *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Seizures or convulsions *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Weakness in limbs *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nervous System - Cognitive Function

Challenged in ability to relax *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experience food allergies *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Experiencing confusion or brain fog *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experience difficulty to retain memory *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Experience a short concentration span *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Inability to sit still and need to fidget *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

History of Stressful Events in the last 24 months

Death of a family member or close friend *

☒ No ☐ Yes

Financial challenges *

☐ No ☒ Yes

Marital challenges *

☐ No ☒ Yes

Personal injury or illness *

☒ No ☐ Yes

Starting a new job *

☒ No ☐ Yes

Divorce or Separation *

☒ No ☐ Yes

Loss of work *

☒ No ☐ Yes

Moving house *

☒ No ☐ Yes

Retirement *

☒ No ☐ Yes

Violations of the law *

☒ No ☐ Yes

Insomnia Relevant Assessment

Can't switch off, overthinking and worrying *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Consume food after 7pm *

☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Consume caffeine after 2pm or chocolate close to bedtime *

☒ 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

Respiratory System

Blood in sputum (phlegm or spit) when coughing *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Cold's or flu's has a tendency to go the chest really quickly *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Offensive breath or foul smelling sputum *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Shallow breathing - not filling the lung to capacity *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Snoring loudly *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Wheezing or purring when breathing *

- ☒ Never ☐ Sometimes ☐ Regularly ☐ Always

Chest pain when breathing *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Frothy sputum *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Persistent cough - dry or moist *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Short of breath without strenuous exercise *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Sputum are thick yellow, green or brown *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Integumentary System: Skin, Hair & Nails

Do you experience any of the following?

Acne *

- ☐ Never ☒ Sometimes ☐ Regularly
☐ Always

Eczema / Dermatitis *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nails - pitted *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nails - weak or brittle *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Dandruff *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Moles that have changed in size or colour *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nails - thickened *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Nails - discolouring *

- ☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Pigmentation - decreased *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Psoriasis *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Redness, discoloured path of skin OR itch without explanation *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Pigmentation - increased *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Rashes - unexplained *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Warts *

☒ Never ☐ Sometimes ☐ Regularly
☐ Always

Detoxification - Sensitivities

Do you experience an ...**Allergy or sensitivity to sodium benzoate or potassium benzoate ***

☒ No ☐ Yes

Allergy or sensitivity to caffeine *

☒ No ☐ Yes

Allergy or sensitivity to alcohol (even in small amounts) *

☒ No ☐ Yes

Allergy or sensitivity to Tyramine (found in red wine, cheese, bananas, chocolate)? *

☒ No ☐ Yes

Allergy or sensitivity to chemicals that include perfumes, exhaust fumes, smoke or strong odours? *

☒ 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?

A+

Please type unknown if you are not sure.

Please check all that apply to your immediate family: *

<input type="checkbox"/> Asthma / Lung disorders	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular Disease	<input checked="" type="checkbox"/> Diabetes 1 or 2	<input type="checkbox"/> History of Back Pain
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> Psychiatric Disorders	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> 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 everything 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. If you cancel / reschedule your appointment within 48 hours, you will be required to secure your next appointment with full payment.

Please sign here *



Date *

11/09/2022