

# INITIAL CASE TAKING FORM

PATIENT NAME:

AGE:

D.O.B. :

GENDER:



## Patient Motivation Profile

### CURRENT MEDICATIONS/ SUPPLEMENTS

*Note dosage and duration of use:*

### PRESENTING COMPLAINT

*This section is intended to provide an overall snapshot of the patient's state of health/disease at the first consultation. Include detailed information about the main presenting complaint/s, e.g. COLDSIPA (character, onset, location, duration, severity, pattern, associated factors).*

### FAMILY HISTORY

## PATIENT PRESENTATION:

Gastrointestinal and liver health (e.g. digestion and elimination)

Endocrine and Reproductive (e.g. adrenal health, hormonal health, blood glucose control, thyroid function)

Immune and Inflammation (e.g. history of infections, signs of inflammation)

Nervous system (e.g. mental health, cognitive health)

Musculoskeletal (e.g. injuries, arthritis, pain)

Cardiovascular and circulation (e.g. blood pressure, circulation)

Respiratory (e.g. breathing quality, history of infection)

Renal (e.g. stones, history of infection)

## TIMELINE OF MAJOR HEALTH AND LIFE EVENTS

BIRTH

PRESENT DAY

## DIET

*Include main findings regarding diet.*



**Diet and Exercise Record**

## LIFESTYLE/OCCUPATION

## STRESS MANAGEMENT

*Investigate what represents stress for your patient and how they manage that stress.*

## EXERCISE

*Enquire about the type, duration and frequency of exercise.*

## RESULTS FROM QUESTIONNAIRES/POINT OF CARE TESTS/PATHOLOGY HIGHLIGHTS

TREATMENT:

INITIAL TREATMENT/R.O.F

*Outline your initial treatment strategy, including treatment goals, product prescription, and lifestyle interventions.*

FURTHER NOTES AND REMINDERS FOR FOLLOWING CONSULTATION: