ENERGISED HEALTH @ Burleigh Heads Physio

PLEASE COMPLETE CAREFULLY

Name.....Date: / /
Address.....P/Code.....
Phone (H).....(Mob).....(W)..... Sex.....
Email..... D.O.B / / M/S/D children #:...
Weight:..... Height:..... Occupation:..... Health Fund:.....
Major Illnesses.....
Current Complaint.....
medications/supplements:.....
Current Complaint:.....
.....
FamilyHistory.....
.....

CIRCLE IF YOU EAT, USE OR DO: -

Addictions	Alcohol	Cordial	Breakfast Cereal	Little Exercise
Cigarettes	Coke	Chocolate	Make up	Drink little water
Recreational drugs	Coffee	Sugar	Perfumes	Drink filtered water
Crave Foods	Soft drink	artificial sugars	Exposure to chemicals	Use the Pill
Margarine	Milk	Lollies	Amalgam Fillings	Blood type.....
Deli meats	Tea	Frozen vegetables	Number of bowel movements / day.....	

Instructions: - Circle the score in the column that best suits your symptoms, in either Severity or Frequency.
Column **A** = ***Never*** or rarely *Note:* please circle zeros as well as numbers
Column **B** = ***Mild*** or infrequent symptoms (0nce per month or less)
Column **C** = ***Moderate*** or frequent symptoms (weekly)
Column **D** = ***Severe*** or highly frequent symptoms (more than 3 times weekly)

1. Bones/ Joints

	A	B	C	D
Neck ache	0	2	4	7
Back pain	0	2	4	7
Spinal problems	0	2	4	7
Osteo/ Rheumatoid arthritis	0	2	4	7
Bursitis or tendonitis	0	2	4	7
Joint stiffness	0	2	4	7

***Total*.....**

2. Muscles

Tight back, neck muscles	0	2	4	7
Muscle cramps/ spasms	0	2	4	7
Ticklish	0	2	4	7
Poor flexibility	0	2	4	7
Trembling/ twitching	0	2	4	7

***Total*.....**

3. Cardiac

Chest tightness on stress/exertion	0	2	5	10
Pain down left chest/ arm	0	2	5	10
Previous angina	NO	YES	(10)	
Known heart condition	NO	YES	(15)	
High cholesterol / triglycerides	NO	YES	(15)	
Heart/ circulatory medications	NO	YES	(15)	

***Total*.....**

4 & 5. Circul.

Cold hands / feet	0	3	7	10
Thickened or deformed toe nails	0	3	7	10
Dizziness	0	3	7	10
Feeling blushed	0	3	7	10.
High blood pressure	0	7	15	20

***Total*.... ..**

6. Lungs

Asthma / wheezing	0	2	5	10
Chronic cough	0	2	5	10
Bronchitis	0	2	5	10
Difficulty breathing	0	2	5	10
Phlegmy	0	2	5	10

***Total*.....**

7. Digestion

	A	B	C	D
Bloating after meals	0	2	5	10
Burping	0	2	5	10
Flaking or peeling nails	0	2	5	8
Bad breath	0	2	5	8
Upper abdominal pain	0	2	5	8

***Total*.....**

8. Gastric

Past stomach ulcers	NO	YES	(8)	
Stomach ulcer currently	NO	YES	(10)	
Use of antacids	0	3	7	10
Heart burn	0	3	7	10

***Total*.....**

9. Pancreas. D

Diarrhea / constipation	0	2	5	7
Tiredness after meals	0	1	3	5
Smelly stools	0	2	5	7
Indigestion / fullness	0	2	5	7
Flatulence	0	2	5	7
Food allergies	0	3	5	8

***Total*.....**

10. Large. I

Fungal / thrush infections	0	3	5	8
Bad taste in mouth on awakening	0	3	5	8
Antibiotic use in past 12 months	NO	YES	(10)	
Lower abdominal bloating	0	3	5	8
Sore or bleeding gums	0	3	5	8

***Total*.....**

11. Liver

Hepatitis / jaundice	NO	YES	(5)	
Headaches after eating	0	3	5	8
Yellowness in whites of eyes	0	3	7	10
Indigestion after fatty food	0	3	5	8
Fluid retention	0	2	4	7
High cholesterol / triglycerides	0	3	5	8
Chemical / pollutant exposure	0	3	5	10

***Total*.....**

12.Low Immune

	A	B	C	D
Ear infections/ stuffed up ears	0	3	7	10
Long or frequent colds or/ flu	0	3	7	10
Swollen glands	0	3	7	10
Cold sores	0	3	7	10
Mucous in throat	0	3	7	10
Throat infections	0	3	7	10
				Total.....

13. Allergy

Hay fever / sinusitis	0	5	10	15
Eczema/ Psoriasis	0	3	7	10
Asthma/ bronchitis	0	3	7	10
Headaches	0	3	7	10
Food sensitivity/ allergy	0	3	7	10
Runny nose	0	3	7	10
				Total.... ..

14. Adrenals

Fatigue	0	2	5	7
Poor tolerance to stress	0	2	5	7
Salt cravings	0	2	5	7
Low exercise energy	0	2	5	7
Drink coffee to feel up	0	3	7	10
Dizzy upon standing	0	2	5	7
Rapid mood swings	0	2	5	7
				Total.....

15. Thyroid

Feel cold often	0	3	7	10
Irregular menstruation	0	1	3	5
Fertility problems	NO	YES	(8)	
Depression / apathetic	0	1	3	5
Bulging eyes	0	2	5	10
Low sex drive	0	1	3	5
Thick peeling nails	0	3	5	8
Puffy wrinkly skin	0	3	5	8
				Total.....

16.Blood sugars

Crave sweets	0	3	5	8
Leg ulcers	0	3	5	8
Headache relieved by food	0	3	5	8
Tired or sleepy after lunch	0	3	7	10
Morning dull headaches	0	3	5	8
				Total.... ..

17.Kidneys

Strong body odour	0	3	7	10
Difficulty holding urine	0	3	7	10
Poor urine stream	0	3	7	10
Cloudy urine	0	3	7	10
Urinary infections	0	3	7	10
				Total.....

18.Pre Menstrual

Anxiety/ irritable before period	0	3	7	10
Pain/ cramping	0	3	7	10
Cravings for sugar/ chocolate/ salt	0	3	7	10
Dizziness/ fatigue	0	3	7	10
Depression/ crying	0	3	7	10
Breast tenderness	0	3	7	10
Fluid retention	0	3	7	10
				Total.....

19.Fertility

Irregular/ delayed periods	0	3	7	10
Miscarriages	NO	YES	(10)	
Venereal diseases	NO	YES	(10)	
Endometriosis	NO	YES	(10)	
Polycystic ovaries	NO	YES	(10)	
				Total.....

20. Periods

Fatigue with periods	0	3	7	10
Heavy blood flow/ clots	0	3	7	10
Nausea with periods	0	3	7	10
Abdominal pain or cramping	0	3	7	10
Headache/ migraine with period	0	3	7	10
				Total.....

21.Oestrogen/progest

Ovarian cysts. Fibroids	NO	YES	(10)	
Breast lumps/ congestion	0	3	7	10
Heavy blood flow	0	3	7	10
Period of more than 5days	NO	YES	(10)	
Long total cycle (over 30 days)	0	3	7	10
Scanty blood flow	0	3	7	10
Irritable /irrational/mood swings	0	3	7	10
Hirsuitness (E.g. facial hair)	0	3	7	10
				Total.....

23.Males

Difficulty urinating/post drip	0	3	7	10
Venereal diseases (STD'S)	NO	YES	(10)	
Pain in testicular area	0	3	7	10
Erectile difficulties	0	3	7	10
				Total.....

24. Nerves

Trembling hands	0	3	7	10
Uncoordinated	0	3	7	10
Stressed	0	3	7	10
Tummy knots	0	3	7	10
Nervous/ anxiety	0	3	7	10
				Total.....

25.N.E

Stroke	NO	YES	(15)	
Alzheimer's disease	NO	YES	(15)	
Nerve/ motor disorders	NO	YES	(15)	
				Total.....

26. Pain

Chronic pain	0	8	12	18
Headaches/ migraine	0	8	12	18
Back pain	0	8	12	18
Medication dependant for pain	0	5	10	15
				Total.....

27.Emotions

Medications for depression etc	NO	YES	(15)	
Depressive	0	3	7	10
Panic attacks	0	3	7	10
Mood swings	0	3	7	10
Irritable/ irrational/ vague	0	3	7	10
				Total.....

28. Sleep

Can't fall asleep	0	1	5	7
Restless uneasy sleep	0	1	5	7
Intense dreams	0	1	3	5
Exhausted after sleep	0	1	3	5
				Total.....

OFFICE POLICY - In the interests of all patients, if you are unable to attend this office at the time of your appointment, 24 hours notice is required so that others may utilise this time, otherwise a **non cancellation fee will be applied**. Consultation and supplement fees are required to be paid at the time of your appointment. Prior arrangements may be accepted however outstanding fees will incur an accounting fee. I also agree to receive newsletters sent at the discretion of the clinic…

I declare that the above information I have given is true and correct and I agree to abide by the Office Policy.

Signed.....