



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:.....

 Family History.....

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 (Once 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	Neck ache	A	B	C	D	7. Digestion	Bloating after meals	A	B	C	D
	Back pain	0	2	4	7		Burping	0	2	5	10
	Spinal problems	0	2	4	7		Flaking or peeling nails	0	2	5	8
	Osteo/ Rheumatoid arthritis	0	2	4	7		Bad breath	0	2	5	8
	Bursitis or tendonitis	0	2	4	7		Upper abdominal pain	0	2	5	8
	Joint stiffness	0	2	4	7						
Total.....											
2. Muscles	Tight back, neck muscles	0	2	4	7	8. Gastric	Past stomach ulcers	NO	YES	(8)	
	Muscle cramps/ spasms	0	2	4	7		Stomach ulcer currently	NO	YES	(10)	
	Ticklish	0	2	4	7		Use of antacids	0	3	7	10
	Poor flexibility	0	2	4	7		Heart burn	0	3	7	10
	Trembling/ twitching	0	2	4	7						
Total.....											
3. Cardiac	Chest tightness on stress/exertion	0	2	5	10	9. Pancreas. D	Diarrhea / constipation	0	2	5	7
	Pain down left chest/ arm	0	2	5	10		Tiredness after meals	0	1	3	5
	Previous angina	NO	YES	(10)			Smelly stools	0	2	5	7
	Known heart condition	NO	YES	(15)			Indigestion / fullness	0	2	5	7
	High cholesterol / triglycerides	NO	YES	(15)			Flatulence	0	2	5	7
Heart/ circulatory medications	NO	YES	(15)		Food allergies	0	3	5	8		
Total.....											
4 & 5. Circul.	Cold hands / feet	0	3	7	10	10. Large. I	Fungal / thrush infections	0	3	5	8
	Thickened or deformed toe nails	0	3	7	10		Bad taste in mouth on awakening	0	3	5	8
	Dizziness	0	3	7	10		Antibiotic use in past 12 months	NO	YES	(10)	
	Feeling blushed	0	3	7	10		Lower abdominal bloating	0	3	5	8
	High blood pressure	0	7	15	20	Sore or bleeding gums	0	3	5	8	
Total.....											
6. Lungs	Asthma / wheezing	0	2	5	10	11. Liver	Hepatitis / jaundice	NO	YES	(5)	
	Chronic cough	0	2	5	10		Headaches after eating	0	3	5	8
	Bronchitis	0	2	5	10		Yellowness in whites of eyes	0	3	7	10
	Difficulty breathing	0	2	5	10		Indigestion after fatty food	0	3	5	8
	Phlegmy	0	2	5	10		Fluid retention	0	2	4	7
Total.....											
							High cholesterol / triglycerides	0	3	5	8
							Chemical / pollutant exposure	0	3	5	10
Total.....											

	A	B	C	D		A	B	C	D		
12.Low Immune	Ear infections/ stuffed up ears	0	3	7	10	19.Fertility	Irregular/ delayed periods	0	3	7	10
	Long or frequent colds or/ flu	0	3	7	10		Miscarriages	NO	YES	(10)	
	Swollen glands	0	3	7	10		Venereal diseases	NO	YES	(10)	
	Cold sores	0	3	7	10		Endometriosis	NO	YES	(10)	
	Mucous in throat	0	3	7	10		Polycystic ovaries	NO	YES	(10)	
	Throat infections	0	3	7	10		Total.....				
	Total.....										
13. Allergy	Hay fever / sinusitis	0	5	10	15	20. Periods	Fatigue with periods	0	3	7	10
	Eczema/ Psoriasis	0	3	7	10		Heavy blood flow/ clots	0	3	7	10
	Asthma/ bronchitis	0	3	7	10		Nausea with periods	0	3	7	10
	Headaches	0	3	7	10		Abdominal pain or cramping	0	3	7	10
	Food sensitivity/ allergy	0	3	7	10		Headache/ migraine with period	0	3	7	10
	Runny nose	0	3	7	10		Total.....				
	Total.....										
14. Adrenals	Fatigue	0	2	5	7	21.Oestrogen/progest	Ovarian cysts. Fibroids	NO	YES	(10)	
	Poor tolerance to stress	0	2	5	7		Breast lumps/ congestion	0	3	7	10
	Salt cravings	0	2	5	7		Heavy blood flow	0	3	7	10
	Low exercise energy	0	2	5	7		Period of more than 5days	NO	YES	(10)	
	Drink coffee to feel up	0	3	7	10		Long total cycle (over 30 days)	0	3	7	10
	Dizzy upon standing	0	2	5	7		Scanty blood flow	0	3	7	10
Rapid mood swings	0	2	5	7	Irritable /irrational/mood swings	0	3	7	10		
	Total.....					Hirsutiness (E.g. facial hair)	0	3	7	10	
	Total.....					Total.....					
15. Thyroid	Feel cold often	0	3	7	10	23.Males	Difficulty urinating/post drip	0	3	7	10
	Irregular menstruation	0	1	3	5		Venereal diseases (STD'S)	NO	YES	(10)	
	Fertility problems	NO	YES	(8)			Pain in testicular area	0	3	7	10
	Depression / apathetic	0	1	3	5		Erectile difficulties	0	3	7	10
	Bulging eyes	0	2	5	10	Total.....					
	Low sex drive	0	1	3	5	24. Nerves	Trembling hands	0	3	7	10
Thick peeling nails	0	3	5	8	Uncoordinated		0	3	7	10	
Puffy wrinkly skin	0	3	5	8	Stressed		0	3	7	10	
	Total.....						Tummy knots	0	3	7	10
16.Blood sugars	Crave sweets	0	3	5	8		Nervous/ anxiety	0	3	7	10
	Leg ulcers	0	3	5	8	Total.....					
	Headache relieved by food	0	3	5	8	25.N.E	Stroke	NO	YES	(15)	
	Tired or sleepy after lunch	0	3	7	10		Alzheimer's disease	NO	YES	(15)	
	Morning dull headaches	0	3	5	8		Nerve/ motor disorders	NO	YES	(15)	
	Total.....					Total.....					
17.Kidneys	Strong body odour	0	3	7	10	26. Pain	Chronic pain	0	8	12	18
	Difficulty holding urine	0	3	7	10		Headaches/ migraine	0	8	12	18
	Poor urine stream	0	3	7	10		Back pain	0	8	12	18
	Cloudy urine	0	3	7	10		Medication dependant for pain	0	5	10	15
	Urinary infections	0	3	7	10	Total.....					
	Total.....					27.Emotions	Medications for depression etc	NO	YES	(15)	
18.Pre Menstrual	Anxiety/ irritable before period	0	3	7	10		Depressive	0	3	7	10
	Pain/ cramping	0	3	7	10		Panic attacks	0	3	7	10
	Cravings for sugar/ chocolate/ salt	0	3	7	10		Mood swings	0	3	7	10
	Dizziness/ fatigue	0	3	7	10	Irritable/ irrational/ vague	0	3	7	10	
	Depression/ crying	0	3	7	10	Total.....					
	Breast tenderness	0	3	7	10	28. Sleep	Can't fall asleep	0	1	5	7
Fluid retention	0	3	7	10	Restless uneasy sleep		0	1	5	7	
	Total.....						Intense dreams	0	1	3	5
	Total.....						Exhausted after sleep	0	1	3	5
	Total.....					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.....