Naturopathic Essential Health

Initial Client Health Assessment Form

Male/Female/Child

Fill in as much detail as possible and attach any recent medical test or photos

Please indicate if filling in this form for a minor (person under 18)

Please note you must be the minor's parent/legal guardian to continue with this form

Please read carefully and acknowledge the Naturopathic Consultation Consent form on the last page

Name:		**Date:**	
Address:		**Phone number:**	
		Mobile:	
Female/Male:		**Email:**	
Date of Birth:		**Occupation:**	
Partner Status:		**Children/ages:**	

Are you filling in this form for a minor: **Yes** / **No**

Are you the minor's parent/legal guardian: **Yes** / **No** (please note you must be the minor's parent/legal guardian to continue with this form)

Should you be filling in this form for a minor, please write the minors name and details in the box above and write your full name and relationship with the minor here:

Main Concern you would like improved or treated in this consultation:

When did symptoms or conditions start:

Pain: (sharp/dull/throbbing/numb) Scale 1/10 - 1 being low pain

What aggravates the symptoms or conditions:

Personal medical history: (past trauma, accidents, injuries, operations, broken bones etc and when).

Recent medical tests or investigations: (include test results)

Diagnosed Conditions: (when diagnosed and by whom).

Medications taken: (inhalers, insulin, statins, steroids, anti-inflammatories, antacids or others)

Supplements taken: (vitamins, minerals, protein shakes, other)

Allergies: (food, gluten, lactose, wheat, drugs, chemicals, pets, dustmites, perfume)

When did you last take antibiotics:

Emotional state at present: (if yes please indicate on a scale of 1/10 - 10 being the worst)

Anxious:

Panic attacks:

Chronic worrier:

Irritable:

Sadness:

Restless:

Angry:

Argumentative:

Happy:

Relaxed:

Perfectionist:

Need to be around people:

Prefer your own company:

Sleep patterns:

Time to bed:

Normal wake up time:

Do you have any problems going to sleep:

Do you have problems staying asleep:

How many times do you wake during the night:

Do you wake feeling refreshed:

Do you suffer from leg or feet cramps during the night:

Do you remember your dreams: (few, many, pleasant, unpleasant, recurring themes)

Energy levels: scale from 1 -10: (1 being low energy)

Have you experienced in the last two years: (divorce, separation, loss of work, death of a loved one)

Do you suffer from: Depression, Obsessive compulsive disorder, bi polar or other: When was it diagnosed and by whom

Do you suffer from:

Cold sores:

Bad breath:

Cracked lips:

Dry lips:

Bleeding gums:

Grind teeth:

Difficulty or pain when swallowing:

Do you suffer from:

Short/long sightedness:

Cataracts:

Dry eyes:

Itchy eyes:

Watery eyes:

Dark circles under the eyes:

Do you suffer from:

Congested or blocked nose:

Runny nose:

Frequent sneezing:

Do you suffer from:

High or low blood pressure:

High cholesterol:

Cold hands or feet:

Chest pain or heart palpitations:

Bruise easily:

Swollen feet or ankles:

Do you suffer from: (describe body part affected, how long you have been suffering the condition for and how do you treat it at present)

Itchy skin:

Dry flaky skin:

Eczema:

Psoriasis:

Dermatitis:

Acne:

Dandruff:

Do you suffer: (what parts of the body and how do you treat the conditions)

Arthritis:

Osteoarthritis:

Rheumatoid arthritis:

Gout:

Do you suffer:

Painful periods:

Cramping:

Irregular periods:

Fluid retention:

Sore breasts:

Mood swings/crying/irritability:

How many days do you menstruate for:

Do you have to change your tampon or pad more than every three hours:

Do you get mid cycle bleeding:

Is there any clotting:

Do you suffer from:

Vaginal discharge: (odor and color)

Genital or groin rash, irritation or itchiness:

Painful intercourse:

Fibroids:

Endometriosis:

Polycystic ovaries:

Painful testicles:

Pain with ejaculation:

Are you pregnant: If so how many months:

Are you breast feeding:

Do you take oral contraceptives: (what brand and how long for)

julie@natesshealth.com.au

Have you been through menopause:

Do you suffer night sweats or hot flushes:

Do you have trouble concentrating:

Do you suffer from frequent urinary infections: (if so, how often and how do you treat the infections)

Do you have difficulty starting urine flow, or poor flow of urine:

Is your urine colour: clear, cloudy, yellow or contains blood

Does your urine have a strong odor:

Are you currently seeing any other health practitioners: Please provide details

Family medical history: Grandparents, Parents, Aunts, Uncles or Siblings

(heart problems, diabetes, high/low blood pressure, asthma, depression, cancer, other)

Hobbies: interests, sports, exercise (in recent times)

Average Daily Diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Daily intake of: (what type, how much & how often)

Water:

Caffeine (milk & sugar):

Soft drinks:

Alcohol:

Tobacco:

Do you add salt to your food:

Are you a vegetarian or vegan:

Are there any foods that you crave on a daily basis:

julie@natesshealth.com.au

Are there any foods you do not eat:

Do you experience reflux, heartburn or indigestion:

Do you suffer flatulence after eating:

Do you or have you suffered from an eating disorder: (explain in detail)

What is your current weight and height:

Would you like to lose or gain weight: (if so how much)

Bowel Motions:

How often:

Color: light, dark, brown or black:

Float or sinks:

Consistency: liquid, soft, firm or hard:

Straining or urgency:

Blood or mucous in stools:

Do you feel full evacuated after using bowels:

Do you suffer with itchy anus:

Body Signs: (To be filled out by the naturopathic practitioner)

Face:

Iris:

Tongue:

Nails:

Blood Pressure:

Naturopathic Consultation Consent Form

Modern naturopathy includes traditional knowledge and skills combined with therapeutic understanding, continual training, research, evidenced based practice and available diagnostic. Naturopathic therapeutic strategies are used to treat holistically the whole person mind, body and spirit (soul) with diet and life style improvements, herbal medicine, mineral therapy, nutritional supplementation and other modalities.

Naturopathic medicines for the most part are considered safe and side effect free, however reactions to these natural medicines may occur. Although uncommon a person may have an allergic reaction to a specific herb or aggravate a pre-existing symptom or condition.

Caution must be used when treating certain conditions such as pregnancy, diabetes, heart, kidney or liver disease. The **responsibility of the client** is paramount in informing the naturopathic practitioner of any medications taken, any known aliment's or if the client is pregnant, suspect they are pregnant or breast feeding.

Initially and for a short period of time I understand I may experience worsening of certain symptoms or a new symptom may appear. This is generally considered a positive reaction as the body is removing accummulated toxins from tissues, cells and organs. This process is called a Healing Crisis.

As the client I acknowledge that the interaction between herbs and some prescribed drugs, although unlikely may have an adverse reaction or experience an increase/reduction in the effect of other medications. I understand that it is my responsibility to inform my doctor of any treatment or supplements I may receive from a naturopathic consultation. I acknowledge that I have been advised not to alter or cease prescribed medication without consulting the prescribing doctor/practitioner.

The naturopath's roll is to provide optimal client healthcare based upon the facts known to them and within their scope of practice. I do not expect the naturopath to be able to predict/know or explain all risks and complications. I understand that results may not be guaranteed.

A record will be kept by the naturopathic practitioner of my personal health history. This record will be kept confidential and will not be released to others without my direct consent or my representative's direct consent or unless required by law.

Private health funds may not pay benefits to their members for a consultation that is not face to face or in the physical presence of a practitioner. Please contact your health fund provider for further information.

A phone consultation of 30 minutes is included with all initial health assessments conducted by email. (Australian phone numbers only). A convenient time will be negotiated via email or text message.

Tick the box to give consent ☐ I have fully read and understand the above information and hereby give consent to Julie Ann Garner for an online & in clinic naturopathic consultation.

Full Name_____ Date_____

***Please note: to submit your form, please pay and upload your saved form via our website www.naturopathicessentialhealth.com.au/online-consultation**