133 Catherine St Leichhardt NSW 2040
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Patient Information Form

Confidentiality assured

Date: Referred by:

Name	
Date of Birth	
Address	
Hm phone	Fax
Mobile	
Email □ Tick if you would prefer not to receive our emails	
Occupation	
Height	Weight
Next of Kin	Phone

GP	Suburb
Specialist	Suburb

Please list your main concerns, diagnosed conditions and reasons for this appointment

1. _____

2. _____

3. _____

Have you had any investigations/ tests/ operations / hospitalisations. Please list.

_____
_____
_____
_____

Have you experienced major stress in the last 12 months?

_____
_____
_____
_____

Current medications, herbal or nutritional supplements

Name	Dose

Social history

Cigarettes/tobacco – amount/day
Alcohol – units/day
Recreational drugs – type, frequency
Caffeine beverage intake – type, amount per day
Exercise – type, duration, frequency
Relaxation - type, duration, frequency
Water intake – glasses/day
Allergies / Intolerances / Foods You Avoid

General Health Questionnaire

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if you have never experienced this symptom.

Gastro-intestinal	Respiratory	Skin	Cardiovascular
☐ Bloating ☐ Flatulence ☐ Reflux/Heartburn ☐ Indigestion ☐ Nausea ☐ Abdominal pain ☐ Constipation ☐ Diarrhea ☐ Food intolerances	☐ Persistent cough ☐ Sneezing, wheezing ☐ Post nasal drip ☐ Ear infections ☐ Itchy eyes, ears, nose, throat ☐ Sore throat	☐ Slow wound healing ☐ Acne ☐ Psoriasis ☐ Dry, flaky skin ☐ Oily skin ☐ Eczema / skin rashes	☐ Excessive fatigue ☐ Shortness of breath ☐ Easy bruising or bleeding ☐ Palpitations ☐ Dizziness ☐ Varicose veins ☐ High blood pressure ☐ High cholesterol
Immune/Lymphatic	**Sleep**	**Emotional**	**Musculoskeletal**
☐ Poor immunity ☐ Recurrent cold / flu ☐ Hayfever / sinusitis ☐ Fluid retention ☐ Cold sores ☐ Inflammed / bleeding gums ☐ Auto-immune disease ☐ Cancer	☐ Insomnia ☐ Difficulty falling asleep ☐ Waking during night ☐ Waking un-refreshed ☐ Regular dreaming ☐ Night sweats	☐ Depression ☐ Anxiety ☐ Mood swings ☐ Poor memory ☐ High stress levels ☐ Feelings of being overwhelmed or unable to cope	☐ Headaches ☐ Migraines ☐ Muscle aches or cramps ☐ Joint pain ☐ Restless legs ☐ Muscle weakness
Endocrine	**Urinary / Renal**	**Male hormone balance**	**Female hormone balance**
☐ Fatigue / poor energy ☐ Recent weight gain ☐ Heat / cold intolerance ☐ Hair falling out ☐ Abdominal weight gain ☐ Thyroid disorder	☐ Excessive urination ☐ Frequent urination ☐ Pain with urination ☐ Incontinence ☐ Bloody, cloudy or smelly urine☐ Urinary tract infection	☐ Low libido ☐ Difficulty starting urine flow ☐ Premature ejaculation ☐ Difficulty maintaining erection ☐ Genital rash or irritation ☐ Painful testicles	☐ Hot flushes ☐ Night sweats ☐ Change in menstrual cycle ☐ Dry hair, skin or vagina ☐ Low libido ☐ Excessive libido ☐ Bleeding after intercourse ☐ Infertility ☐ Miscarriage
Pre-menstrual symptoms (women only)	**Menstrual symptoms (women only)**	**Sexual Health**	**Lifestyle**
☐ Depressed or teary ☐ Anxious or irritable ☐ Feeling aggressive or angry ☐ Breast tenderness ☐ Food cravings ☐ Fluid retention/bloating ☐ Back pain ☐ Abdominal pain ☐ Headaches or migraines	☐ Long intervals between cycles ☐ Cycles longer than 32 days ☐ Cycles shorter than 24 days ☐ Heavy blood flow or flooding ☐ Passing of blood clots ☐ Very light blood flow ☐ Spotting before or after bleed ☐ Period pain	☐ Thrush ☐ Genital herpes ☐ Sexually transmitted disease ☐ Irregular pap smear ☐ Painful intercourse ☐ Burning or itching pain on genitals	☐ Smoker _____ / day ☐ Passive smoker ☐ Coffee _____/ day ☐ Tea _____/ day ☐ Alcohol _____ /week ☐ Recreational drugs ☐ Exercise ___ / week ☐ Excessive plane travel ☐ Radiation exposure ☐ Pesticide / herbicide exposure ☐ Bleach and ammonia use (cleaning) ☐ High stress levels

Please turn over for last page

Medical History – Self and family - please circle or tick

	Self	Mother's side	Father's side
Allergies			
Arthritis			
Asthma			
Autoimmune disease			
Bowel disorder			
Cancer			
Cardiovascular disease			
Depression			
Diabetes			
Eczema or Psoriasis			
Epilepsy			
Endometriosis			
Fibroids			
Gastroenteritis/Giardia etc			
Hepatitis			
Hospitalisations/operations			
Hysterectomy			
Osteoporosis			
Sexually transmitted disease			
Thyroid disease			
Other			

3 DAY DIET DIARY

This diet diary should be completed prior to your appointment with your naturopath and brought with you to your appointment. Please include as much details as possible eg. Type of bread used on sandwiches, whether food is packaged, takeaway or fresh, any dressings or oils used in cooking, any drinks etc….

DAY 1	DAY 2	DAY 3
Breakfast	Breakfast	Breakfast
Morning snack	Morning snack	Morning snack
Lunch	Lunch	Lunch
Afternoon snacks	Afternoon snacks	Afternoon snacks
Dinner	Dinner	Dinner
Other snacks	Other snacks	Other snacks

Water Intake per day –

Coffee/teas per day –

Alcohol per day -