Confidential Naturopathic Screening Questionnaire

Date	
Name	
Address	
Ph	Mobile
Email Address	
Date of Birth	Age
If patient is a child :	
Mothers name:	Fathers Name:
Next of Kin	
Referral Source	
GP	
Have you received naturopathic care recently?	If yes: date last treated
Name of Practitioner:	
Have you received Chiropractic care recently?	If yes: date last treated
Name of Chiropractor	
For what reason?	
Other Health Care Practitioners (HCP) visited?	
Name of other HCP	

Please take a few moments to fill out the following pages, any queries can be completed during your interview with your Naturopath, thank you…

A fee of $70 will be charged for missed appointments and if less than 3 days notice is given for a cancellation.

I have read and understood the charge to apply for missed appointments.
Signed _____

Dated ……..

Confidential Screening Questionairre

What would you like to achieve by the end of our consult / What is your goal?

Are you willing to make significant lifestyle and dietary changes – such as eliminating wheat or dairy from your diet? I will ask you to do this.

How committed are you in improving? Obtaining and maintaining health takes work and dedication.

What are all symptoms you currently are experiencing? List in order of irritation and severity for you.

How long has each symptom been present?

What are your current diagnoses? How long have you been diagnosed with each one?

Digestive System

Gas, bloating, indigestion or belching? If yes, describe when and frequency.

Describe the frequency and appearance of your bowel movements.

Do you have difficulty waking up?

Do you get dizzy on standing?

Do you have access to a sauna?

What is your blood pressure on average?
Last use of antibiotics? What for? Probiotics taken afterwards?

History of being prescribed and taken oral Flagyl, Tetracycline, Antacids, Antifungals, Steroids?

List all medications you are taking – including over-the-counter.

How many times do you wake up to urinate?
What do you do for a living?

Sleep

Do you have regular sleeping habits?_____How many hours per night? _____
Difficulty with it in any way? Difficulty falling asleep, early riser, nightmares etc:
Please Describe. _____
_____
_____
_____

Lifestyle

Birth date _____ Blood type _____

Weight_____Height _____

Are you satisfied with your present weight?_____
Have you ever had a weight problem?_____
Do you exercise regularly? YES / NO If YES How often? _____
What type of program?_____

Do you challenge yourself to stimulating activities that challenge your brain daily?
If so what? _____

Do you meditate or use any relaxation exercise?_____
What hobbies do you do frequently?

_____
What are the significant stressors in your life? How you dealing with them?

_____
What are your outlets to reduce stress and increase relaxation/amusement?

_____
How often do you play with a pet? _____

Eating and Nutritional assessment:

Overall, please list your 5 favourite foods: • Overall, please list your 5 favourite drinks:

1._____ 1. _____
2._____ 2. _____
3._____ 3. _____
4._____ 4. _____
5._____ 5. _____

Any food or drink cravings? List them. What foods do you avoid? List them.

1._____ 1._____
2._____ 2. _____
3._____ 3. _____
4._____ 4. _____
5._____ 5. _____

Why do you avoid these foods?

_____
What tends to make you feel better?

_____
What tends to make you feel worse?

_____
Do you eat foods containing gluten? YES/NO

- If YES, how often?

_____
Do you smoke? YES/NO

- If YES, how often?

_____
How much alcohol do you drink on average? Why do you drink it? Social? To relax? Like the taste?

_____
How many cups of coffee or caffeinated tea you drink in a day? Energy drinks?

_____
Are you prepared to modify your diet in order to achieve the best outcome for your health?
YES/NO
Are there any obstacles you can see to stop you achieving your goals of healthy eating?

_____

Goals 3 months health goal?

BIG QUESTION HERE: Please answer this at home and in your own time….
"What is it that stands in the way of you being at peace?"

Any recent lab work? If so, what were the key findings?

Are you happy with your current doctor(s)? Explain?

What do you think caused your symptoms? Main cause.

Do you think you can get better?

How do you feel in the morning?

How do you feel in the evening?

When is the last time you felt good?

Any significant changes before you got sick? New house? New job? Travel? Fired? Mould? Death in family? Bites?

What supplements do you KNOW make you feel good?

What supplements do you KNOW make you feel terrible?

Have you ever done an elimination diet? If so why and how did you feel?

Please provide a food diary for seven days leading up to your initial appointment. If you could also note any symptoms next to each day also. Please email me if you would like a template sent for this.

Metabolic Screening Questionnaire

Rate each of the following symptoms based upon your health profile in the last 30 days…

POINT SCALE:

0=*Never or almost never* have the symptom
1=*Occasionally* have it, effect is *not severe*
2=*Occasionally* have it, *effect is severe*
3=*Frequently* have it, effect is *not severe*
4=*Frequently* have it, effect is *severe*

Digestive tract	_____	Nauseau or vomiting	**Total**
	_____	Diarrhoea	
	_____	Constipation	
	_____	Bloated Feeling	
	_____	Belching, or passing gas	
	_____	Heartburn	_____
Ears	_____	Itchy Ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in Ears, Hearing Loss	_____
Emotions	_____	Mood Swings	
	_____	Anxiety, fear or nervousness	
	_____	Anger, Irritability, or aggressiveness	
	_____	Depression	_____
Energy / Activity	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	_____
Eyes	_____	Watery or Itchy Eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
		Blurred or tunnel vision	
		(does not include near/far sightedness)	
Heart	_____	Irregular or skipped heartbeat	
	_____	Rapid or Pounding Heartbeat	
	_____	Chest Pain	
	_____	Faintness	_____
Head	_____	Headaches	
	_____	Dizziness	
	_____	Insomnia	_____
Joints/ Muscles	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	_____
Lungs	_____	Chest Congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	_____

Mind

_____ Poor Memory Total
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making descisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Mouth/ Throat

_____ Chronic coughing Total
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discoloured tongue, gums, lips
_____ Canker sores

Nose

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucous formation _____

Skin

_____ Acne
_____ Hives, rashes, or dry skin
_____ Hair loss
_____ Flushing or hot flashes

Weight

_____Binge eating/drinking
_____ Craving certain foods
_____ Excessive Weight
_____ Compulsive eating
_____ Water retention
_____ Underweight _____

Other

_____Frequent Illness
_____ Frequent or urgent urination
_____ Genital itch or discharge _____

Grand total _____
Comments:

Metabolic Screening Questionnaire

Please answer the following Questions by ticking the most appropriate answer:

	YES	NO
1. Have you ever been treated with Antibiotics?		
2. Have you ever had problems with Yeast infections?		
3. Do you eat or crave a lot of sweet foods?		
4. Do you have a problem with food allergies?		
5. Have you suffered from any food poisoning?		
6. Do you or have you consumed alcohol on a regular basis?		
7. Have you ever taken the drugs Zantec or Tagamet?		
8. Do you take aspirin , panadeine, nurofen, or other pain killers?		
9. Do you take other types of drugs regularly?		
10. Are you often in contact with organic chemicals (ie:insecticides, herbicides, petrochemicals?)		
11. Do you react to strong perfumes, car exhaust, etc?		
12. Do you or have you ever smoked or used tobacco products?		
13. Are you exposed to passive cigarette smoke?		
14. Do you consume beverages / food containing caffeine?		
15. Do you consume organic foods		
16. Has any of your family been diagnosed with a genetic problem?		
17. Have you ever had an operation?		
18. If yes, for what?		

LIVER DETOXIFICATION TEST (LDT) SCREENING QUESTIONS

A certain percentage of people will experience adverse reactions during liver detoxification. This reactions include, but are not limited to shakiness, headaches, nauseau, palpitations, light headedness, and sweating. The following questions will help isolate those patients who may experience these types of reactions.

A. Do you react when you consume caffeine-containing beverages or food?_____

B. Are you sensitive to food additives such as M.S.G.?_____

C. Do you have a history of liver problems? _____
If Yes Please describe the problem:_____

_____

D. Are you currently taking any drugs? If yes please list below: Please bring all medications with you at your next visit.

_____

E. List all supplements you are taking and what time of day you are taking them.

_____

_____

Thankyou for answering your health profile. All questionnaires are confidential and an important part of your overall health assessment. Please keep it with you and hand to your practitioner.

Comprehensive Menstrual & Hormone Questionnaire

Women only

1. What Day Are You In Your Cycle Now?
2. What Was The Length Of The Last Cycle (I.E. 28 Days?)
3. How Long Was The Bleed? (I.E. 3, 4 ,5 Days?)
4. Any Stopping And Starting With The Bleed?
5. Any Clots In The Blood? -What Was The Colour Of The Blood?
6. Any Mucous At Any Stage During Your Last Cycle Or During This Cycle?
7. Did You Experience Any Breast Pain During The Last Cycle Or Bleed?
8. Did You Experience Any Headaches, Dizziness, Or Back Pain?
9. How Is Your Libido?
10. How Were Your Emotions Leading Up To Your Period?
11. How Were They During The Period?
12. How Are They Now?
13. How Are Your Energy Levels?

    Pre Cycle,

    During

    And Now?
14. How Are Your Bowel Movements?
15. Are They Regular?

    Is The Stool Loose, Normal Or Hard? (Circle please)
16. Have You Experienced Any Bloating Or Nausea?