



Health History Form

Bring this completed form to your first appointment.

Consent

Please read the following important information:

1. You have the right to make decisions regarding your health and any treatment recommendations.
2. Treatment recommendations will be based on the information you provide.
3. Nutritional supplements and herbs are generally regarded low-risk and although due care will be taken to avoid any adverse reactions (e.g. temporary aggravation of symptoms, allergic reaction), it is not always possible to determine when such a response may occur.
4. If deemed necessary, aspects of your health may be reviewed with other healthcare professionals and in doing so, extreme care will be taken to protect your identity.

By signing this form, you are acknowledging that you understand and consent to the points listed above.

Signature Date: / /

Personal Details

Name: Email:

Phone number (home): (mobile):

Address:

Date of birth: ____ / ____ / ____ Age: ____ Occupation:

Next of kin name: Contact number:

Primary Health Concern(s)

Please describe the symptoms you are experiencing and list any other health concerns you have:

Indicate the severity of your symptoms (mark X at the most appropriate place on the scale):

1	2	3	4	5
minor impact on your life		moderate impact on your life		severe impact on your life

Medical History

When was your last menstrual period? _____

Has your menstrual cycle become: ☐ *more frequent* ☐ *less frequent* ☐ *irregular* ☐ *no change* ☐ *n/a*

Has the length of your period become: ☐ *longer* ☐ *shorter* ☐ *no change* ☐ *n/a*

Has your menstrual flow become: ☐ *heavier* ☐ *lighter* ☐ *no change* ☐ *n/a*

Do you have a **family history** of any of the following?

☐ Auto-immune ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Other (*please specify*)

Please indicate if any of the following are applicable to you and provide details:

Pre-existing medical condition(s): Yes / No _____

Accidents/injuries/surgeries: Yes / No _____

Allergies: Yes / No _____

Do you smoke cigarettes? ☐ *currently* ☐ *in the past* ☐ *never*

List all **pharmaceutical medications** (prescription and over-the-counter) that you are currently taking and have taken within the past one month:

Name of medication	Prescribed by	Dose	Duration	Reason for taking

List all **supplements, herbs** and/or **homeopathy** that you are currently taking:

Name	Brand	Dose	Duration	Reason for taking

Diet, Exercise & Sleep

Do you have any food intolerances? (Please specify): _____

List any foods you crave (e.g. sweet, salty or particular foods): _____

Please list the types of foods you eat on a **regular basis** (include non-alcoholic drinks e.g. juice, fizzy drinks, tea, coffee, hot chocolate). Include foods that you eat both during the week and on weekends.

	Time	Foods & non-alcoholic drinks
Breakfast		
Morning snacks		
Lunch		
Afternoon snacks		
Dinner		
Evening snacks		

How much water do you drink: _____ litres/day Number of alcoholic drinks per week: _____

List any **exercise** you do on a regular basis:

Type of exercise (e.g. walking, swimming, gym, sport, yoga)	Frequency (no. of times per week)	Duration (minutes per session)

How many hours sleep do you usually get on: weekdays: _____ weekends: _____

Do you experience difficulty getting to sleep? ☐ usually ☐ sometimes ☐ never

Do you experience difficulty staying asleep? ☐ usually ☐ sometimes ☐ never

Symptom Review

Using the scale below, indicate your average **energy** levels (mark X at the most appropriate place on the scale):

1 2 3 4 5
extremely low energy good amount of energy lots of energy

Using the scale below, indicate your average **stress** levels (*mark X at the most appropriate place on the scale*):

1	2	3	4	5
<i>hardly ever stressed</i>		<i>sometimes stressed</i>		<i>always stressed</i>

Please indicate if you experience any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Hot flushes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Chronic phlegm / mucus | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Swollen lymph nodes | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Varicose veins / spider veins |
| <input type="checkbox"/> Recurrent infections (bacterial/viral) | <input type="checkbox"/> Low libido | <input type="checkbox"/> Haemorrhoids |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Oedema / fluid retention | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Receding gums | <input type="checkbox"/> Urinary leakage e.g. when laughing | <input type="checkbox"/> Tension around neck & shoulders |
| <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Recurrent urinary tract infections | <input type="checkbox"/> Muscle pain / spasms |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Acne | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Cracked skin e.g. heels, fingers or lips | <input type="checkbox"/> Twitching eyelids |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Numbness / tingling sensations |
| <input type="checkbox"/> Low iron / anaemia | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Nerve pain |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Oily skin | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Fungal infections (incl. athletes foot) | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Discomfort after eating fatty foods | <input type="checkbox"/> Skin conditions e.g. eczema, rosacea | <input type="checkbox"/> Sensitivity to noise |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Warts | <input type="checkbox"/> Sensitivity to bright light |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Stretch marks | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Loose stools / diarrhoea | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Low mood |
| <input type="checkbox"/> Flatulence / belching | <input type="checkbox"/> Oily hair | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Split ends | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Hair thinning / loss | <input type="checkbox"/> Lack of mental clarity |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Excessive perspiration | <input type="checkbox"/> Fuzzy head e.g. cotton wool sensation |
| <input type="checkbox"/> Period pain e.g. cramping | <input type="checkbox"/> Excessive foot odour | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Menstrual clots | <input type="checkbox"/> Cold hands / feet | <input type="checkbox"/> Poor memory |

Other

Is there any other information relevant to your health that has not been covered in this form?

- ☐ Tick if you would like to receive my quarterly e-newsletter (containing my latest health articles).

Thank you for taking the time to fill in this form.