New Patient Intake Form

Please complete this form as accurately as possible and email completed form to believetoachieveholistichealth@gmail.com before your appointment or bring with you to initial consultation.

PERSONAL INFORMATION

Name:	Sex: □ M □ F
D.O.B: Current age:	Occupation:
Country of Birth:	Cultural Heritage:
Address:	Email:
Phone:	Mobile phone:
Doctors Contact Details:	Emergency contact:
Height:	Weight:

MAIN HEALTH CONCERN

What is the main health issue of concern?

.....

.....

Have you received any recent diagnosis? If yes, by whom and when?

.....

.....

Have you had this health issue treated before? If yes, when and how was it treated?

.....

.....

MEDICATIONS

Are you currently taking any prescribed or non prescribed medications? If yes, please fill in the table below.

Medication	Strength	Dosage	Frequency	Since	Reason for taking

SUPPLEMENTS

What nutritional or herbal supplement(s) are you currently taking if any? Please fill in the table below

Supplement	Brand	Dosage	Frequency	Since	Reason for taking

ALLERGIES

Are you allergic or intolerant to any medications, herbs, supplements?

…..……..……..……

…..……..……..……

Do you have any known food allergies/intolerances? If so, what are they?

…..……..……..……

…..……..……..……

Do you have any environmental/chemical sensitivity? (I.e. pollen, dust, animal fur/hair, etc)

…..……..……..……

…..……..……..……

MEDICAL HISTORY

Please list any major surgeries, illnesses and injuries that you have had:

Infanthood:

……

……

Childhood:

……

……

Adolescence:

……

……

Adulthood:

……

……

FAMILY HISTORY

Please list any health concerns of family members including siblings, parents and grandparents?

Mother:

……

……

Father:

……

……

Siblings:

……

……

Other (Children, Grandparents, Aunts, Uncles, Cousins):

……

……

0449 132 801
believetoachieveholistichealth@gmail.com
www.believetoachieveholistchealth.com.au

DENTAL

Do you have any amalgam fillings? If yes, how many? …….……..

Do you have any root canals? If yes, how many? ……..……..

SLEEP

How many hours do you sleep per night? ……..……..

Do you have difficulty falling asleep? ……..……..

Do you wake up during the night? If yes, what time? ……..……..

Do you feel rested on waking? ……..……..

LIFESTYLE

What are your main interests and hobbies? ……..……..

Do you exercise? If yes what type and how often? ……..……

Does exercising make you feel better? ……..……..

Do you smoke? If yes how long for and how many per day? ……..……

Do you use recreational drugs? If yes, which ones? ……..……

How would you rate your stress out of 10 (10 being the highest): ……..……..

How would you rate your energy out of 10 (10 being the highest): ……..……

DIET

Please describe your typical daily diet?

Breakfast: ……..……..

Lunch: ……..……..

Dinner: ……..……..

Snacks: ……..……..

Drinks: ……..……..

How much of the following do you consume per day/week?

Water (glasses/day):	Coffee (cups/day):	Tea (cups/day):
Sugar (tspns/day):	Alcohol (drinks per day/week):	Soft drink (glasses/day):

General Health Questionnaire

Please check boxes with a tick for condition you have now and a cross for past condition. Please leave boxes blank if you have never had this condition.

Skin

- ☐ Nail changes
- ☐ Rashes
- ☐ Eczema
- ☐ Acne
- ☐ Psoriasis
- ☐ Itching
- ☐ Hives
- ☐ Burning
- ☐ Dryness
- ☐ Excessively oily
- ☐ Wounds heal quickly
- ☐ Slow wound healing
- ☐ Unpleasant odour
- ☐ Moles changing colour
- ☐ Moles bleeding

Eyes

- ☐ Impaired vision
- ☐ Watery
- ☐ Dry
- ☐ Itchy
- ☐ Blurry vision

Ears

- ☐ Earache
- ☐ Discharge
- ☐ Infection
- ☐ Ringing in ears

Nose & Sinus

- ☐ Congestion
- ☐ Runny nose
- ☐ Loss of smell

Mouth & Throat

- ☐ Frequent sore throat
- ☐ Bleeding gums
- ☐ Mouth ulcers
- ☐ Swollen glands
- ☐ Tonsilitis issues
- ☐ Tongue changes

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease
- ☐ Chest pains
- ☐ Palpitations/Flutters
- ☐ Murmurs
- ☐ Angina

Peripheral Vascular

- ☐ Cold hands/feet
- ☐ Varicose veins
- ☐ Easy bleeding
- ☐ Bruise easily
- ☐ Anemia
- ☐ Swollen Ankles

Respiratory

- ☐ Cough
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ COPD

Breasts

- ☐ Lumps
- ☐ Fibrocystic breasts
- ☐ Pain
- ☐ Nipple/areola changes
- ☐ Discharge

Urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Frequent infections
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Wake at night to urinate

Gastrointestinal

- ☐ Heartburn/reflux
- ☐ Nausea/Vomiting
- ☐ Regular bowel movements
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating
- ☐ Hemorrhoids
- ☐ Abdominal pain
- ☐ Flatulence
- ☐ Ulcer
- ☐ Gall stones
- ☐ Rectal itchiness

Endocrine

- ☐ Fatigue
- ☐ Fever/chills
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Thyroid disorder
- ☐ Excessive sweating
- ☐ Diabetes
- ☐ Low blood sugar
- ☐ Weight gain
- ☐ Weight loss

0449 132 801
believetoachieveholistichealth@gmail.com
www.believetoachieveholistchealth.com.au

Musculoskeletal

- ☐ Joint pain/stiffness
- ☐ Arthritis
- ☐ Joint changes
- ☐ Cramps/Spasms
- ☐ Muscle pain/weakness
- ☐ Back pain
- ☐ Neck pain
- ☐ Restless legs
- ☐ Motor vehicle accident

Neurological

- ☐ Headache
- ☐ Migraine
- ☐ Head injury
- ☐ Dizziness
- ☐ Fainting
- ☐ Stroke
- ☐ Seizures
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Vertigo
- ☐ Balance issues
- ☐ Insomnia/sleep problems

Emotional/Mental Health

- ☐ Depression
- ☐ Anxiety
- ☐ Excess stress
- ☐ Tendency to dwell on stressful situations
- ☐ Poor concentration
- ☐ Forgetfulness
- ☐ Racing thoughts
- ☐ Brain fog
- ☐ Memory issues

Immunity

- ☐ Serious infection
- ☐ Warts
- ☐ Hepatitis
- ☐ Yeast overgrowth
- ☐ Fungal infections
- ☐ Cancer
- ☐ Frequent colds
- ☐ Flu
- ☐ Autoimmune disease

Female Reproductive

- ☐ Age menses began: .....
- ☐ Duration of menstrual flow: ..... days
- ☐ Length of entire menstrual cycle: ..... days
- ☐ Regular cycles
- ☐ Bleeding between periods
- ☐ Heavy flow
- ☐ PMS symptoms
- ☐ Clotting
- ☐ Low libido
- ☐ Excessive libido
- ☐ Hot flushes
- ☐ Night sweats
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Infertility
- ☐ Miscarriage
- ☐ Are you sexually active
- ☐ Sexually transmitted infection
- ☐ Abnormal cells on pap smear test

Male Reproductive

- ☐ Testicular masses
- ☐ Testicular pain
- ☐ Are you sexually active
- ☐ Sexual difficulties
- ☐ Low libido
- ☐ Sexually transmitted infection
- ☐ Discharge
- ☐ Sores
- ☐ Prostate issues
- ☐ Erectile dysfunction
- ☐ Date of last prostate exam: .....

Do you have any other health issues of concern that you would like to share at this time or if there is something that has not been covered please list them below?

…..……..……..……

…..……..……..……

…..……..……..……

If you have any recent pathology test results or radiology reports, please bring them along to your appointment.

Declaration

I have read, understood and completed this intake form and questionnaire. I declare that all information I have given is true and correct.

Patient Name: .....

Signature of patient (or guardian):

Date ___/___/___

Informed Consent

I (Patient's Name) _____ have chosen to consult with and hereby give consent for naturopathic treatment to be provided by Nicole Ross who I understand is a Naturopath and Clinical Nutritionist at Believe To Achieve Holistic Health.

I have provided a detailed medical history. I do not expect the naturopath/clinical nutritionist to have foreseen any previous or pre-existing condition that I have not mentioned.

I understand that naturopathic and/or nutritional treatments may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of pain, better sleep, more energy, reduction of symptoms of stress-related conditions and provision of general wellbeing.

I also understand that naturopathic and/or nutritional treatment may produce some possible health risks which include, but not limited to aggravation of pre-existing symptoms and possible reactions to herbal or nutritional supplements such as allergies, gastrointestinal disturbances and increases in blood pressure.

I am aware that the naturopath/nutritionist is not a doctor, does not diagnose specific illnesses, prescribe or adjust medications.

The naturopath/clinical nutritionist understands that I have the right to question treatments used and to receive an explanation of any treatments that the naturopath/ clinical nutritionist prescribes.

I will tell the naturopath/clinical nutritionist about any health risks I may experience and understand that treatments used will be adjusted accordingly.

Patient's Signature (or Guardian's):_____ Date: _____

Privacy Policy

Believe To Achieve Holistic Health is committed to the privacy of its patients. Personal information is treated as confidential and is used only for the purpose for which it was collected.

Information kept on file will not be released to any third party without the express consent of the patient (or guardian) or as required by law.

0449 132 801
believetoachieveholistichealth@gmail.com
www.believetoachieveholistchealth.com.au