CLIENT CONSULTATION

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

EMAIL: _____

GENDER: _____

DOB: _____

AGE: _____

SCALE WEIGHT: _____

HEIGHT: _____

HOW CAN WE HELP? WHAT ARE HOPING TO ACHIEVE?

_____

_____

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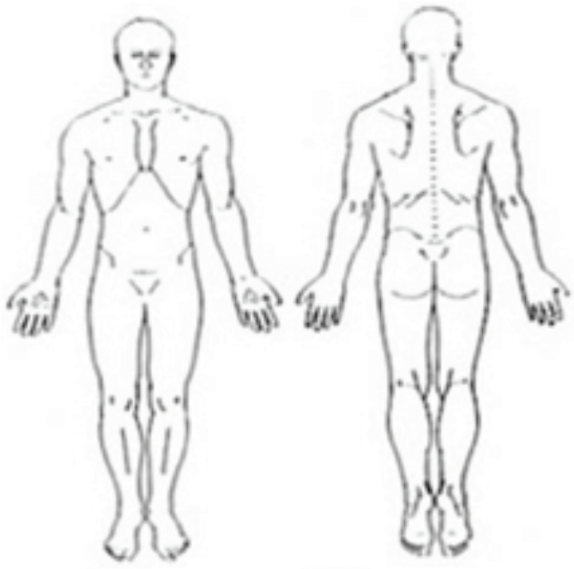
PRESENTING SYMPTOMS:

PLEASE CIRCLE AREA'S YOU ARE IN PAIN IF ANY?



HISTORY OF PRESENTING SYMPTOMS [WHAT'S HAPPENED, TIMELINE, PROGRESSION ETC]:

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SYSTEMS REVIEW
(START WITH THOSE MOST RELEVANT TO THE PRESENTING SYMPTOMS!)

DIGESTIVE SYSTEM

MOUTH:
- □ ULCERS
- □ BLEEDING GUMS
- □ BAD BREATH
- □ TASTE
- □ CRACKED LIPS
- □ TEETH PROBLEMS
- □ OTHER _____

_____

_____

UPPER DIGESTION:
- □ HUNGER
- □ HEARTBURN/INDIGESTION
- □ BURPING
- □ BELCHING
- □ NAUSEA
- □ BLOATING
- □ VOMITING
- □ OTHER _____

_____

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LOWER DIGESTION:
- □ FLATULENCE
- □ CONSTIPATION/DIARRHEA
- □ HEMORRHOIDS
- □ CRAMPING
- □ BLOATING, PAIN (LOCATION/ SENSATION)
- □ JAUNDICE OR HEPATITIS
- □ OTHER SYMPTOMS _____

BOWEL HABITS: _____


□ SEPARATE HARD LUMPS


□ LUMPY AND SAUSAGE LIKE


□ SAUSAGE SHAPE WITH CRACKS ON SURFACE


□ SMOOTH, SOFT SAUSAGE OR SNAKE


□ SOFT BLOB WITH CLEAR-CUT EDGES


□ MUSHY CONSISTENCY WITH RAGGED EDGES


□ LIQUID CONSISTENCY WITH NO SOLID PIECES

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CARDIO-VASCULAR SYSTEM

HEART:

- □ HIGH BLOOD PRESSURE
- □ CHEST PAIN - DISCOMFORT LEVEL
- □ PALPITATIONS
- □ ANGINA
- □ DYSRHYTHMIA
- □ DIZZINESS ON STANDING
- □ PAIN ON EXERCISE
- □ FAINTING
- □ OEDEMA IN LEGS
- □ OTHER _____

NERVOUS/SENSORY AND EMOTIONAL/PSYCHOLOGICAL SYSTEM

HEAD:

- □ HEADACHES
- □ MIGRAINES
- □ TENSION
- □ VERTIGO/DIZZINESS
- □ NECK PAIN
- □ LIGHT HEADED
- □ OTHER _____

_____

_____

EMOTIONAL/PSYCHOLOGICAL:

- □ DEPRESSION
- □ ANXIETY
- □ PANIC ATTACKS
- □ MOOD CHANGES
- □ PHOBIAS
- □ OTHER _____

_____

_____

_____

ENDOCRINE SYSTEM

- □ THYROID (HEAT/COLD, SWEATING)
- □ DIABETES (THIRST, HUNGER, POLYURIA)
- □ HYPOGLYCEMIA (LOW BLOOD SUGAR)
- □ WEIGHT
- □ OTHER _____

_____

_____

_____

_____

_____

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URINARY SYSTEM

- □ UTI'S OR CYSTITIS
- □ PAIN
- □ NOCTURIA
- □ STONES
- □ FREQUENCY/URGENCY
- □ BURNING
- □ INCONTINENCE
- □ DRIBBLE
- □ OTHER _____

_____

_____

_____

_____

IMMUNE SYSTEM

- □ INFECTIONS
- □ HEALING TIME
- □ GLANDS
- □ SWELLING
- □ FREQUENCY OF INFECTIONS
- □ OTHER _____

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MALE REPRODUCTIVE SYSTEM	
□ PROSTRATE PROBLEMS □ INFECTION □ DISCHARGES □ STD'S □ PAINFUL/INTERRUPTED URINATION □ ERECTION PROBLEMS □ LIBIDO □ STD PROTECTION □ CONTRACEPTION □ OTHER _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
SEXUALLY ACTIVE: YES/NO	
STD PROTECTION:	**CONTRACEPTION:**

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FEMALE REPRODUCTIVE SYSTEM

MENSTRUAL CYCLE:

- □ REGULAR
- □ IRREGULAR
- □ DURATION OF MENSES
- □ HEAVY/LIGHT
- □ COLOUR
- □ SPOTTING
- □ PAIN/CRAMPS
- □ PREMENSTRUAL SYMPTOMS
- □ PHYSICAL/EMOTIONAL
- □ OTHER _____

_____

_____

MENARCHE: [HOW OLD]	**LIBIDO:** POOR / GOOD / NO CONCERNS
SEXUALLY ACTIVE: YES/NO	**METHOD OF CONTRACEPTION:**

PREGNANCIES:

- □ BIRTHS
- □ TERMINATIONS
- □ MISCARRIAGES
- □ DIFFICULTY FALLING PREGNANT
- □ COMPLICATIONS
- □ OTHER _____

_____

_____

INFECTIONS:

- THRUSH
- CANDIDA
- PID
- DISCHARGES
- SORENESS
- DRYNESS
- STD'S
- □ OTHER _____

_____

LAST PAP SMEAR: [DATE]	**RESULT:**

REGULAR BREAST EXAMS:	
LAST MAMMOGRAM: [DATE]	**RESULT:**

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PAST MEDICAL HISTORY

ADULT ILLNESSES OR CONDITIONS:

- □ ALLERGIES
- □ ASTHMA
- □ ANAEMIA
- □ DIABETES
- □ HYPERTENSION
- □ HEPATITIS
- □ HIV
- □ MENTAL HEALTH
- □ OTHER _____

_____

_____

_____

_____

OPERATIONS: [PLEASE PROVIDE BRIEF DETAILS INCLUDING DATES]

HOW OFTEN USE ANTIBIOTICS?:

LAST TIME: [DATE] **DO YOU ALWAYS FINISH THE COURSE?:**

OTHER HEALTH PRACTITIONER/S?: (E.G. CHIRO/ OSTEO/ PHYSIO/ ACUPUNCTURE/ KINESIOLOGIST/ COUNSELLOR/ PSYCHOLOGIST)?

BLOOD TESTS: DATE OF LAST:

FAMILY MEDICAL HISTORY

MOTHER: _____

_____

FATHER: _____

_____

GRANDPARENTS:	MATERNAL	PATERNAL
GRANDMOTHER:		
GRANDFATHER:		

SIBLINGS:

YOUR CHILDREN:

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GENERAL HEALTH HISTORY / FACTORS

IN GENERAL HOW WOULD YOU DESCRIBE YOUR HEALTH? ANY RECENT CHANGES?:

- □ USUAL WEIGHT CHANGE
- □ ANY CLOTHES THAT FIT TIGHTER OR LOOSER THAN BEFORE
- □ WEAKNESS
- □ FATIGUE
- □ OTHER _____

_____

_____

HOW WOULD YOU RATE YOUR ENERGY LEVELS (OUT OF 10)?: /10

(1=NO ENERGY, 10= ABUNDANT ENERGY)

SLEEP:

TIME OF BED _____

HOW LONG _____

- □ TROUBLE FALLING ASLEEP
- □ DEEP/UNDISTURBED
- □ LIGHT/WAKE DURING THE NIGHT
- □ WAKE UP REFRESHED

DREAMS –
- □ GOOD
- □ BAD
- □ RECURRING

- □ SNORING
- □ OTHER _____

_____

_____

_____

EXERCISE: [HOW OFTEN DO YOU EXERCISE – TYPE OF EXERCISE]

_____

_____

_____

_____

_____

_____

_____

_____

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GENERAL QUALITY OF LIFE, STRESS LEVELS ETC.

WORK?: _____

_____

_____

_____

_____

RELATIONSHIPS/FAMILY?: _____

_____

_____

_____

HOW WOULD YOU RATE YOUR CURRENT STRESS LEVELS?: /10

(1=NO STRESS, 10= EXTREME)

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW THAT WE HAVEN'T ALREADY DISCUSSED?:

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REGULAR DIET	
BREAKFAST:	MORNING TEA:
LUNCH:	AFTERNOON TEA:
DINNER:	SUPPER:

ARE THERE FOODS YOU CRAVE?
ARE THERE FOODS YOU AVOID?
ANY FOODS OR SUBSTANCES THAT YOU BELIEVE AGGRAVATE OR DON'T AGREE WITH YOU?

HOW MUCH OF THE FOLLOWING WOULD YOU HAVE PER DAY?:

SUGAR: [BROWN/WHITE/SWEETENER]	MILK:
TEA: [TYPE?]	HERBAL TEAS:
COFFEE: [TYPE?]	SOFT DRINKS/CORDIALS:
FRUIT JUICE:	FILTERED WATER:
	TAP WATER:

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MEDICATION / SUPPLEMENTS/ SMOKING / ALCOHOL	
CURRENT MEDICATION - INCLUDING THE PILL: [PLEASE INDICATE REASON; DOSAGE & FREQUENCY]	**CURRENT SUPPLEMENTS:** [PLEASE INDICATE REASON; DOSAGE & FREQUENCY]

DO YOU SMOKE?: YES/NO **HOW MANY:** TYPE:

ALCOHOL?: YES/NO HOW MUCH: HOW OFTEN:

TYPE OF ALCOHOL:

RECREATIONAL SUBSTANCE USE	
CURRENT: [INDICATE DOSAGE & FREQUENCY]	**PAST:** [INDICATE DOSAGE & FREQUENCY]

EXPOSURE TO FARM OR INDUSTRY CHEMICALS (E.G. PAINTING, PRINTING, CLEANING, BEAUTY)?: [INCLUDING WHEN; TYPE]

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NOTES