Stirling Health Professionals

# NATUROPATHY
# NEW PATIENT DETAILS

SURNAME _____ GIVEN NAMES _____ DATE / /

ADDRESS _____

POST CODE _____ REFERRED BY _____

HOME PHONE _____ MOBILE PHONE _____

DATE OF BIRTH _____ OCCUPATION _____

NUMBER OF CHILDREN _____

HEALTH FUND _____ ID NO. ON CARD _____

EMAIL _____

IF UNDER 18 YEARS OF AGE, NAME OF PARENT/GUARDIAN _____

**I acknowledge as part of my consultation with Caroline that she may take a photo of my eyes to assist her in diagnosing my health. Caroline will retain a copy of these photos which may be used in future promotional or research material. If used in the future at no stage will my full name or identifying details be included.**

**Should I have to cancel an appointment for any reason, I agree to give the clinic 24 hours' notice.**

**I understand that I am responsible for missed appointments and will pay fees relating to missed appointments.**

Client/Patient's Signature _____ Date _____

Client/Patient's Name _____

## *HEALTH QUESTIONAIRE*

***Describe in your own words the main reason for attending today:***

_____

_____

***Are there any other health issues you wish to discuss?***

_____

***What things do you think are stopping you from being well?***

_____

## *For women*

Circle those you suffer from:

| | | |
|---|---|---|
| ☐ Irregular Periods | ☐ Period pain | ☐ PMS |
| ☐ Heavy Periods | ☐ Long Periods | ☐ Thrush |
| ☐ Abnormal pap smear | ☐ Libido/fertility problems | ☐ Menopausal symptoms |

When was your last period? _____

Current medication -

_____

Current supplements -

_____

***Rate your levels (1 low -> 10 high***) Energy _____Stress_____

Circle those that apply:

***Do you have a history of using?***

☐ Antibiotics ☐ Anti- inflammatory ☐ Anti – depressants ☐ Steroids

***Are you currently taking/using:*** Recreational drugs: ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No

***Operations you've had & age:***

| | | |
|---|---|---|
| ☐ Gall bladder | ☐ Appendix | ☐ Tonsils |
| ☐ Caesarean | ☐ Hysterectomy | Other_____ |

## *Family history*

***What health concerns run in your family?***

Please circle relevance:

Mother:

☐ cancer ☐ heart disease ☐ Diabetes ☐ Depression ☐ Alcoholism ☐ Osteoporosis thyroid

Father:

☐ cancer ☐ heart disease ☐ Diabetes ☐ Depression ☐ Alcoholism ☐ Osteoporosis thyroid

Siblings:

☐ cancer ☐ heart disease ☐ Diabetes ☐ Depression ☐ Alcoholism ☐ Osteoporosis thyroid

Grandparents:

☐ cancer ☐ heart disease ☐ Diabetes ☐ Depression ☐ Alcoholism ☐ Osteoporosis thyroid

***Are you ready to make the changes to help heal yourself?*** ☐ Yes/No ☐