Riverina
NATURAL
THERAPIES

Patient Questionnaire

To gain the absolute best for your health from our comprehensive services, we ask that you fill in this form. Please take the time to answer all the questions (or as many as you are comfortable with) as honestly and accurately as possible. The more information you are able to provide the better we can tailor your treatment plan. All details will be held in the strictest confidence. Please bring this form completed with you to your first consultation. Thank you.

Please attach with any relevant medical test results from the past 12 months.

Date of First Visit _____

How did you hear of this practice? _____

Surname _____ First Name _____

Address _____

_____ Postcode _____

Home Phone _____ Mobile _____ Work _____

Email _____

Date of Birth _____ Age _____

Occupation _____

Health Insurance Fund _____

Have you had any recent diagnosis by your G.P. or other health professional? Yes / No

If yes, please give details _____

_____

Please explain your main health concern. When did symptoms first appear? _____

_____

Energy

How do you rate your energy levels? Score 1 to 10 (e.g. 1 = Poor and 10 = Great) _____

_____

Other Concerns

Please list any other health concerns you have that you would like to improve _____

_____

How confident are you in making suggested dietary, lifestyle and exercise modifications to improve your health and wellbeing. Rate 1 to 10 (10 being highly committed) _____

GENERAL HEALTH

Have you ever suffered from any of these conditions? (If yes, give dates and details)

Cardio-Vascular disease Yes / No

(Including abnormal blood pressure, high cholesterol, poor circulation, angina, palpitations)

Give details _____

_____

Anxiety/Depression Yes / No

(Give details if on medication, please give details)

_____

_____

Glandular Fever / Chronic Fatigue Yes / No

(Give Details) _____

_____

Other major diseases Yes / No

(Give details) _____

_____

Surgeries Yes / No

(Give details) _____

_____

Do you have any allergies or sensitivities Yes / No

(Give details) _____

_____

How often in the last year have you suffered from infections/colds/flu etc?

Never / Occasionally / Frequently

How many courses of antibiotics have you taken in the last 2 years? _____

Do you have regular (at least once daily) bowel motions? Yes / No

(If no, give details) _____

Do you experience pain/constipation/diarrhoea/flatulence/mucus or blood in stools/heartburn/indigestion/bloating/bad breath? Yes / No

(Give details) _____

_____

Stress

How do you rate your stress levels? Score 1 to 10 (10 is high) _____

How do you feel you are managing your stress levels? _____

Are there things that you do which help you to de-stress? _____

Sleep

What time do you typically go to sleep? _____

How many hours do you sleep per night? _____

Is it easy for you to get to sleep? _____

Are you able to stay asleep during the night? _____

If you are waking during the night, what time do you usually wake up? _____

Do you need to take any supplements or medications to help you sleep? _____

Do you feel refreshed when you wake up? _____

Is there anything else you would like to mention that has not already been covered?

If yes, please list _____

Other

Do you or did you ever smoke cigarettes? Yes / No

(Give details) _____

Do you or did you ever use any recreational drugs (including alcohol)? Yes / No

(Give details) _____

Lifestyle and Environment

Do you currently exercise? Yes / No

If yes, please indicate type of exercise and frequency and duration per week _____

_____

Hobbies and other activities

(Give details) _____

Diet

Please list below the foods and beverages you would consume in an average day. Please be as honest as possible and include in the list biscuits, soft drinks and any other snack foods.

Breakfast _____

Mid Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

Drinks (Amount/Cups per day)
Water/Sparkling/Filtered/Tap _____

Tea (and if you add sugar and how much?) _____

Coffee (and if you add sugar and how much?)_____

Fruit juice/Soft drink _____

Alcohol (Beer/Wine/Spirits) _____

Medications and Supplements

Are you currently taking any pharmaceutical medications? Yes / No

Medication Name	Dosage & Frequency	How long have you been taking this?	What are you using it for?	How long will you need to continue taking it?

Do you have any objections to taking herbal medicine and supplements e.g. religious, can not swallow tablets, can not stand the taste of herbal medicine, etc. Yes / No

Are you currently taking any herbs, vitamins, minerals, etc Yes / No

If yes, please fill in the table

Supplement Name	Dosage & Frequency	How long have you been taking this?	What are you using this for?

Have you had any blood tests or other types of investigations done in the last 12 months? Yes / No

If yes, please list and bring these results with you to your initial consultation.

Informed Consent & Privacy Clearance

I, _____ have been advised by Jenny Powell of Riverina Natural Therapies that she is not a medical doctor and that this clinic is not a medical practice. As such Jenny Powell does not practice or prescribe allopathic medicine. I understand that she is a naturopath and herbalist by Australian Training. As such she seeks to activate and support the self-healing mechanisms of the body. She utilises Naturopathic Medicines and encourages Preventable Health Care in the form of dietary, exercise and lifestyle management.

To the best of my ability all the information given here is a true and accurate representation of my/my child's health.

Signed _____ Date _____

(Signature Parent or Guardian for children under 18 years of age)

Cancellation Policy

Due to the nature of the business, we require 24 hours for cancellation of an appointment. Missed consultations without adequate notice will incur a late cancellation fee of 50% of the consultation charge.