**n ew patient form**   
highlands naturopathy

Today’s Date:

Appointment time and date:

Name:

Address:

Phone:

Email:

Dob:

Allergies:

Occupation:

Emergency contact:

**1.Presenting complaints (please list in priority order)**

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**2.Current medications and or supplements**

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|  | *\*Please include all medications and brands of any natural medicines including dosage and duration that you have been taking the medication for, as well as any other relevant historical information about your medication such as changes and dosage changes.* |

1. **Family medical history**

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1. **Diagnosed illnesses, year of diagnosis, hospitalisations etc**

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1. **Digestive health**

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|  | *Do you experience digestive symptoms? Please highlight any of the below signs as symptoms that relate to you. Please include any other relevant information, such as onset, duration, what makes it better or worse.*   * *Bloating* * *Reflux* * *Gas* * *Abdominal pain* * *Mucus in the stool* * *Blood in the stool* * *Undigested food in the stool* * *Nausea* * *Food reactions* * *Constipation* * *Diarrhoea*   *How many times in the last 5 years have you had antibiotics?*  *What were they prescribed for?*  *When was the last time you had a course of antibiotics?* |

1. **Mental health**

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|  | *Please high light any of the following that are relevant to you and provide details, including onset, duration, progression, what makes it better, what makes it worse.*   * *Depression or a low mood* * *Anxiety* * *Stress* * *Insomnia or disturbed sleep* * *Fatigue* * *Hallucinations* * *Have you ever attempted suicide?* * *Do you ever think about suicide?* * *Are you currently planning suicide?* * *Do you harm yourself or have you ever harmed yourself?* * *Do you experience mood swings, or highs and lows?* * *Do you crave salt or add salt to your meals for flavour?* * *Pins and needles?* * *Muscle twitching?* * *Numbness?* * *Headaches and or migraines?*   *Are you currently seeing a psychologist or psychiatrist as part of your care plan?*  *Please provide the name and contact details of your psychologist if you are happy for your Naturopath to provide a summary of our treatment to integrate your care.*  *Please provide more details about your mental health below:*  *Have you received a diagnosis for a particular mental health condition?*  *When did you receive this diagnosis?*  *What treatments have you tried in the past?*  *What makes your symptoms better?*  *What makes your symptoms worse?*  *What do you do when you feel overwhelmed?*  *How do you manage stress?*  *When did your symptoms first appear?*  *Is there anything else that you feel is contributing to your symptoms?*  *Are there any particular obstacles that you have identified that may get in the way of your progress?*  *How have your symptoms progressed over time?*  *Have they stayed the same, become worse or improved?* |

1. **Immune health**

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|  | *Do you experience any of the following symptoms? Please highlight any relevant signs and symptoms and give details.*   * *Recurrent infections – for example, thrush, cold sores, colds and flu* * *Slow wound healing* * *Recurring fevers* * *Tongue ulcers* * *Urinary tract infections* * *Sinusitis* * *Hay fever* * *Eczema* * *Asthma* * *Psoriasis* * *Recurring sore throat* * *Postnasal drip* * *Have you had glandular fever or any significant infections, bacterial or viral?* |

1. **Thyroid health**

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|  | *Do you experience any of the following? Please highlight and give details below.*   * *Intolerance to heat or cold?* * *Low temperatures or fevers?* * *Significant weight gain or weight loss?* * *Heart palpitations?* * *Tremor?* * *Constipation or diarrhea?* * *Excessive hair loss?* * *Severe fatigue?* * *Brain fog/poor concentration/memory?* * *Irregular periods?* * *Fertility issues?* * *Loss of libido?* * *Dry skin?* * *Hoarseness, need to clear throat often?* * *Sensation as if something is stuck in throat?* * *Mood swings?* * *Aching muscles or joints?* * *High or low blood pressure?* * *Hyperpigmentation of the skin?* |

1. **Women’s health section**

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|  | *How many days is your menstrual cycle? eg. 28 days*  *How many days does the bleed last for?*  *How often do you need to change? heavy bleeding? flooding?*  *Pms? – breast tenderness, mood changes, cravings, fluid retention*  *Are you taking the oral contraceptive pill?*  *Please list which one here:*  *Are you seeking help for menopause?*  *When was your last period?*  *Hot flushes?*  *Vaginal dryness?*  *Excessive hair growth? eg. moustache*  *Do you notice clots in your bleed? what size?*  *Do you take pain killers for period pain?*  *Are you pregnant or breast feeding?*  *Are you planning pregnancy?*  *Do you experience excessive vaginal discharge?* |

1. **Men’s health section**

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|  | *Do you experience the following? please give details?*  *Loss of libido?*  *Have you had a prostate exam?*  *Erectile dysfunction?*  *Difficult urination or disturbed flow?* |

1. **Metabolic health screen**

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|  | *Do you experience any of the following?*  *Frequent urination?*  *Wake through the night to urinate?*  *Frequent thirst?*  *Always hungry?*  *Dizziness?*  *Afternoon energy slump worse after food?*  *Skip meals regularly or go for long periods without eating?*  *Current weight:*  *Height:*  *BMI: weight (kg)/height (metres squared) -*  *Swelling in calves or ankles*  *How much exercise do you do per week?*  *Do you experience chest pain?* |

1. **Environmental exposures**

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|  | *Do you smoke?*  *How many per day?*  *How much alcohol do you consume? eg. amount per/day/week/month/year*  *Do you take recreational drugs?*  *If so how often and what kind?*  *Are you exposed to any mould in your home or workplace?*  *Do you have amalgam (mercury) fillings?*  *How many hours a day do you spend on the computer?*  *Where is your mobile phone when you are asleep at night?*  *Do you drink tap water?*  *Do you eat organic food?*  *Are there any other environmental factors that may be playing a role in your symptoms?* |

1. **Typical diet recall**

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|  | What do you usually eat? Give some examples in the meal types below. Try to be as accurate with your answers as possible to give insight around any potential nutritional deficiencies or food intolerance you may be experiencing.  Breakfast  Lunch  Dinner  Snacks |

1. **Dietary restrictions**

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|  | *Do you restrict any foods from your diet and why?* |

**Best results**

\*For best results and lasting change frequent naturopathy consults are recommended to monitor progress and review your health goals.

The number of consultations required vary from person to person and depend on the nature of your health complaints. We recommend that you continue to see your naturopath for a minimum of 3 – 12 months for optimal results.

Your practitioner will tailor your treatment plan and schedule reviews according to your budget.

**Consent, privacy and correspondence**

Authority to share information.

I …………………………………………………………….. give authority to Jean Martain and Dr…………………………………………………………… and/or Dr…………………………………………………………... to share any relevant medical information pertaining to my case and consultations.

Please sign and date:

Consent, Cancellations, and Privacy

I understand that Jean Martain is a naturopath and will work only within the scope of her practice to assist with my health. I understand that she is not a medical doctor or psychologist, and that she will work with me to identify and rectify the underlying cause/s of my signs and symptoms. I understand that Jean will not recommend that I discontinue or change the dosage of my medication and that my medication must be managed by the prescribing practitioner. I understand that this service does not suggest a cure for my health condition but rather seeks to optimize my health using natural medicines, diet and lifestyle advice.

I consent to naturopathic treatment provided by Jean Martain and acknowledge that complementary medicines may interact with medications and that my practitioner will assess for interactions. I acknowledge that side effects and adverse reactions although rare may occur with complementary medicines.

My personal information will only be used in accordance with the purpose for collection permitted by law with the intention of providing naturopathic health care. Information may be collected via means of initial consultation form, email correspondence, fax, telephone, in clinic consultations, practice management or scheduling software, skype consultations, pathology and specialist reports. I consent to my information being securely stored by practice management software or other secure file storage.

I acknowledge that my information may be disclosed if required by a court of law.

I understand that a $35 cancellation fee applies to appointments cancelled within 48 hours of the scheduled time.

I give permission for my health records to be kept on file by Jean Martain, in full confidentiality. By returning this form (via email or in person) to Jean Martain, I am agreeing to the above terms.

I consent to receive emails from time to time from Highlands Naturopathy regarding natural health information and clinic updates.

Yes:

No:

I consent to my name and contact details being provided to an online patient ordering provider (vital.y/natural script) for online patient ordering and understand that I will receive an email with username and password so I may access online prescriptions from my practitioner.

Yes:

No:

I consent to my contact information details being provided to Nutripath Integrative Pathology and or Laverty Pathology in the request of testing ordered by my practitioner.

Yes:

No:

I agree to notify my practitioner as soon as possible if I experience new symptoms or change my medication.

Please sign and date below:

Please return this form to [admin@highlandsnaturopathy.com.au](mailto:admin@highlandsnaturopathy.com.au) no later than 24 hours prior to your appointment. Thank you for taking the time to complete this questionnaire.

