CLIENT HEALTH EVALUATION

Please complete the following and bring along to your appointment. The information provided will assist us in designing a specialised health plan for you.

Name ____ **Date:** ________________

Mobile Phone: _________________________ Daytime Phone: ______________________

Email: ____

Address: ____

Birth Date: __________________ Gender: __________ Weight: ______kg Height: ______cm

Occupation: ____

Marital status: __________________ Partner's name: _______________ No of Children _____

Current employment: ____

Previous employment: ____

Hobbies: ____

Overseas Travel: ____

Pets: ____

Family History

Allergic to drugs/medications	Depression/anxiety	Heart Disease
Arthritis	Diabetes	High blood pressure
Asthma	Epilepsy	Kidney Disease
Cancer	Glandular / Ross River Fever	TB

Client History - previous and current diseases and conditions

____

____

____

____

____

____

Previous viruses:____

____

Current medications (prescribed and self-prescribed):

____

____

Vitamins/minerals intake:

____

____

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CLIENT HEALTH EVALUATION

Main health concerns/reason for appointment (please rank in order)

____

____

____

____

____

Sleep: Any sleep disturbance? YES / NO (give details) ____________________________

____

____

____

____

____

What time do you usually go to sleep?_______________ Hours of sleep per night? __________

Do you have a clock radio next to your bed? YES / NO

Do you use an electric blanket? YES / NO

Digestion: *Do you experience:* acid reflux YES / NO, burp often YES / NO,
bloating, YES / NO, burning/pain in stomach YES / NO
Other issues? ____

Bowels: *How often do you have a bowel motion?* ____________________________
Amount: normal / too little / a lot *Do you feel fully evacuated?* YES / NO
Consistency: normal / too hard / very soft / diarrhoea
Colour: medium brown / dark brown – black / light clay
Other: mucus, lots of gas, foul smell
Other issues? ____

Urination: *How are your daily urinations?* every 2 to 3 hours / too frequent / sense of urgency, too small amount / too large amount / burning / dribbling / up at night several times

Other issues? ____

Stress: Rate your current stress level on a scale of 1 to 10 (10 being the highest stress): _______

What is the main reason(s) for your stress? ______________________________________

If over level 5, what step(s) are you taking to reduce your stress level? ____________________

____

____

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Do you exercise? YES / NO (specify) ____

____

Electromagnetic Exposure: *How many hours do you spend daily:*

Watching TV? __________ Working on a computer / iPad or similar? _________

Talking on a mobile phone? __________ Wearing a headset? _________

Wearing a wrist-watch *(with battery)*? ________ Wearing a hearing aid? ______

Near electrical equipment for long periods of time *(such as copy machines, high power lines, computers, etc.)*? _______

Do you live or work within 5 km of a cell phone tower? YES / NO

Do you live or work within 30m or less of a power transformer (on a telephone pole)? YES / NO

Vaccinations: ____

____

Have you taken or had injections of ? cortisone YES / NO cytostatic YES / NO

Do you have any metal implants in your body? YES / NO

Do you smoke? YES / NO. Smoked in the past? YES / NO Do you want to quit? YES / NO

Recreational Drugs YES / NO (specify if ever used or experimented)

____

Lived near factories, mines, farming? YES / NO (specify)

____

Contact with pesticides or herbicides or lived near crop spraying YES / NO (specify)

____

Known allergies or reactions to foods, environment or medications

____

Sunlight Amount of natural sunlight you receive daily outside? __________

Amount of sunlight you receive daily through windows?__________

Hours spent daily under fluorescent lights?__________

Eyewear Do you wear contact lenses?________ Glasses?_______ If so, how many hours per day?___________

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CLIENT HEALTH EVALUATION

Women Only: Are you pregnant? _______ Are you breast-feeding? __________

Method of contraception: ________________________________ How long? _______________________

Do you have monthly periods? ________ Date of last menstrual period?_______________________

Are your monthly periods regular (28 day cycles)? ____

Number of days of your menstrual flow?__________

Are you going through menopause?____________ Have your periods stopped? ________

Circle any of the following symptoms you experience associated with your period: cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood.

Other menstrual issues? ____

Emotional/psychological background

Personal & Family History:

____

____

____

____

____

____

____

____

____

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____

Do you have concentration or learning difficulties?

____

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CLIENT HEALTH EVALUATION

Diet

Are there any particular foods or drinks that you would find it difficult not to have every day?

____

____

Do you have any strong favourites as foods or drinks or foods that you crave?

____

____

Are there any particular foods or drinks that you would say you are sensitive to?

____

Sugar cravings? YES / NO Urgent hunger? YES / NO

Daily intake of Sugar____

Daily intake of coffee ____________________ Tea ___________________________________

Do you drink filtered water? YES / NO

Diet -24hr	**Weekdays**	**Weekends**
Breakfast		
Lunch		
Dinner		
Snacks		
Fluid Water, coffee, tea, energy drinks, When, amount		

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CLIENT HEALTH EVALUATION

Symptoms that may be attributable to allergy

Circle the extent to which you experience the following symptoms, leaving blank any that you do not experience, with 1 indicating that you seldom experience it and 5 indicating that it is troublesome to you most of the time.

Head

1	2	3	4	5	Headache
1	2	3	4	5	Migraine
1	2	3	4	5	Sick headaches
1	2	3	4	5	Pressure
1	2	3	4	5	Throbbing
1	2	3	4	5	Stiff neck
1	2	3	4	5	Stabbing

Eyes

1	2	3	4	5	Redness, itching
1	2	3	4	5	Blurred vision
1	2	3	4	5	Sandy or gritty feeling
1	2	3	4	5	Seeing spots or lights
1	2	3	4	5	Dark rings under the eyes
1	2	3	4	5	Watering

Ears

1	2	3	4	5	Ringing in the ears
1	2	3	4	5	Hearing loss
1	2	3	4	5	Itching/redness of the outer ear
1	2	3	4	5	Recurrent ear infections
1	2	3	4	5	Earache

Lungs

1	2	3	4	5	Tightness in chest
1	2	3	4	5	Wheezing
1	2	3	4	5	Hyperventilation
1	2	3	4	5	Coughing
1	2	3	4	5	Poor respiratory function

Nose, throat and mouth

1	2	3	4	5	Metallic taste in mouth
1	2	3	4	5	Mouth ulcers
1	2	3	4	5	Frequent sore throats
1	2	3	4	5	Post-nasal drip
1	2	3	4	5	Stuffy nose
1	2	3	4	5	Sinusitis
1	2	3	4	5	Swelling of mouth, lips or eyes
1	2	3	4	5	Stiffness of throat or tongue
1	2	3	4	5	Sneezing

Gastro-intestinal

1	2	3	4	5	Nausea
1	2	3	4	5	Diarrhoea
1	2	3	4	5	Constipation
1	2	3	4	5	Abdominal bloating
1	2	3	4	5	Flatulence
1	2	3	4	5	Burping
1	2	3	4	5	Gastric reflux
1	2	3	4	5	Abdominal distress

Nervous system

1	2	3	4	5	Difficulty thinking clearly
1	2	3	4	5	Memory loss
1	2	3	4	5	Insomnia
1	2	3	4	5	Difficulty waking up
1	2	3	4	5	Cranky on waking

Depressed mental state

1	2	3	4	5	Melancholy or low mood
1	2	3	4	5	Depression
1	2	3	4	5	Tearfulness
1	2	3	4	5	Feeling withdrawn
1	2	3	4	5	Lack of confidence
1	2	3	4	5	Confusion

CLIENT HEALTH EVALUATION

Skin

1	2	3	4	5	Eczema
1	2	3	4	5	Hives (urticaria)
1	2	3	4	5	Rash
1	2	3	4	5	Itching, dryness
1	2	3	4	5	Blotches
1	2	3	4	5	Excessive perspiration unrelated to exercise
1	2	3	4	5	Chilblains

Overactive mental state

1	2	3	4	5	Irritability
1	2	3	4	5	Tenseness
1	2	3	4	5	Anxiety
1	2	3	4	5	Panic attacks
1	2	3	4	5	Overactivity
1	2	3	4	5	Restlessness
1	2	3	4	5	Destructiveness
1	2	3	4	5	Uncontrollable rage

Cardiovascular

1	2	3	4	5	Rapid or irregular pulse
1	2	3	4	5	Chest pain
1	2	3	4	5	Palpitations, esp. after eating
1	2	3	4	5	Tight chest
1	2	3	4	5	Pain on exercise (angina)
1	2	3	4	5	Elevated blood pressure

Muscoloskeletal

1	2	3	4	5	Swollen, painful joints
1	2	3	4	5	Aching muscles
1	2	3	4	5	Muscular spasm
1	2	3	4	5	Shaking (especially on waking)
1	2	3	4	5	Cramps
1	2	3	4	5	Fibromyalgia
1	2	3	4	5	Restless legs

Genito-urinary

1	2	3	4	5	Premenstrual tension (for women)
1	2	3	4	5	Menstrual difficulties (for women)
1	2	3	4	5	Frequency of urination
1	2	3	4	5	Urgency of urination
1	2	3	4	5	Burning urination
1	2	3	4	5	Genital itch
1	2	3	4	5	Bedwetting

Other symptoms

1	2	3	4	5	Being over- or under-weight
1	2	3	4	5	Fluctuating weight
1	2	3	4	5	Sudden tiredness after eating
1	2	3	4	5	Sudden chills after eating
1	2	3	4	5	Vertigo
1	2	3	4	5	Suddenly feeling unwell
1	2	3	4	5	Feeling unwell all over
1	2	3	4	5	Feeling totally drained and exhausted
1	2	3	4	5	Swelling around eyes, hands, abdomen or ankles

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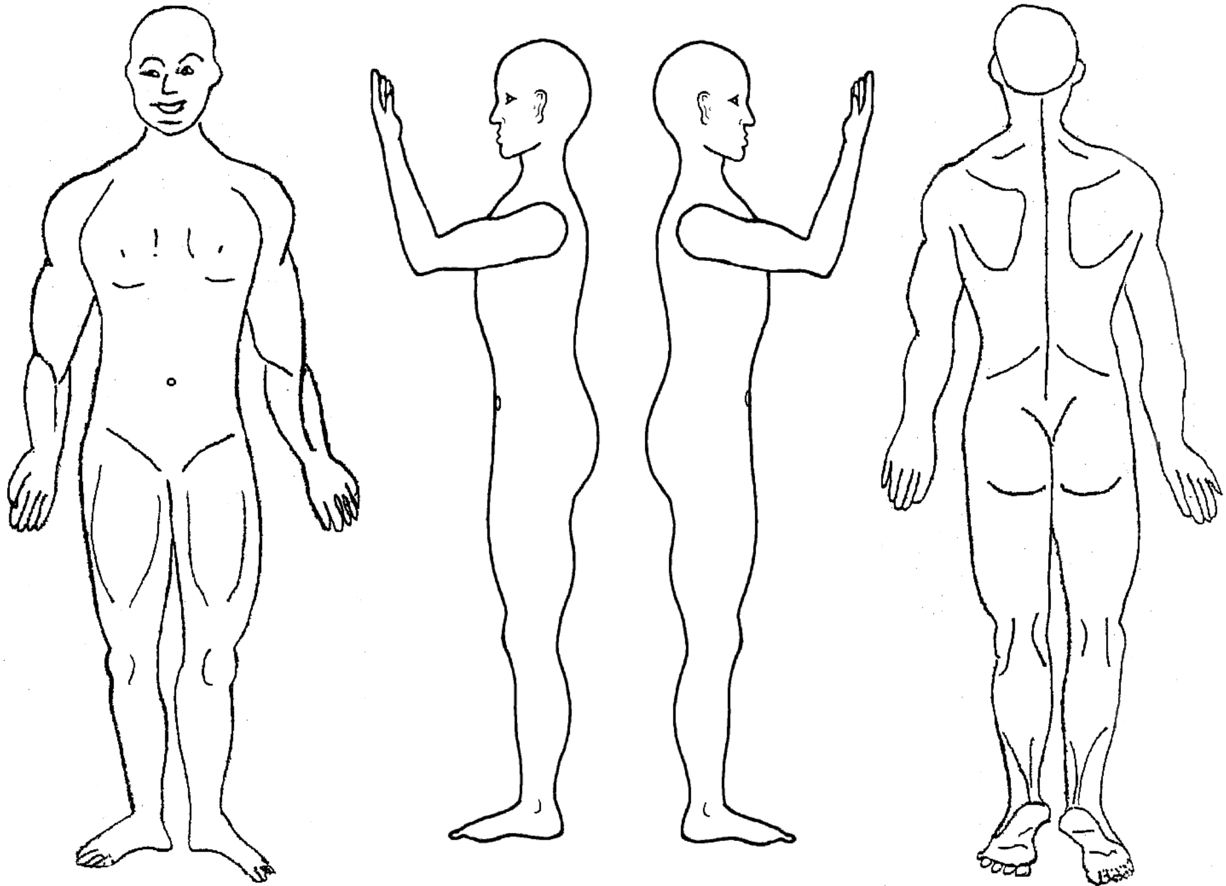
CLIENT HEALTH EVALUATION

Scar/Trauma Chart



Directions

All Scars. Please draw a *red line* on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, all injection sites, old burn areas, etc.

All Trauma Areas. Please put a *red X* where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a *circle* on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury. Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988.")

Important note

Before you arrive for your appointment, please do not take any natural supplements on the day.

Your nails need to be short.. ish (remember they grow back)

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CLIENT HEALTH EVALUATION
Dental History Chart

Dental: Do you have amalgam fillings? YES / NO Dentures/root fillings? YES / NO

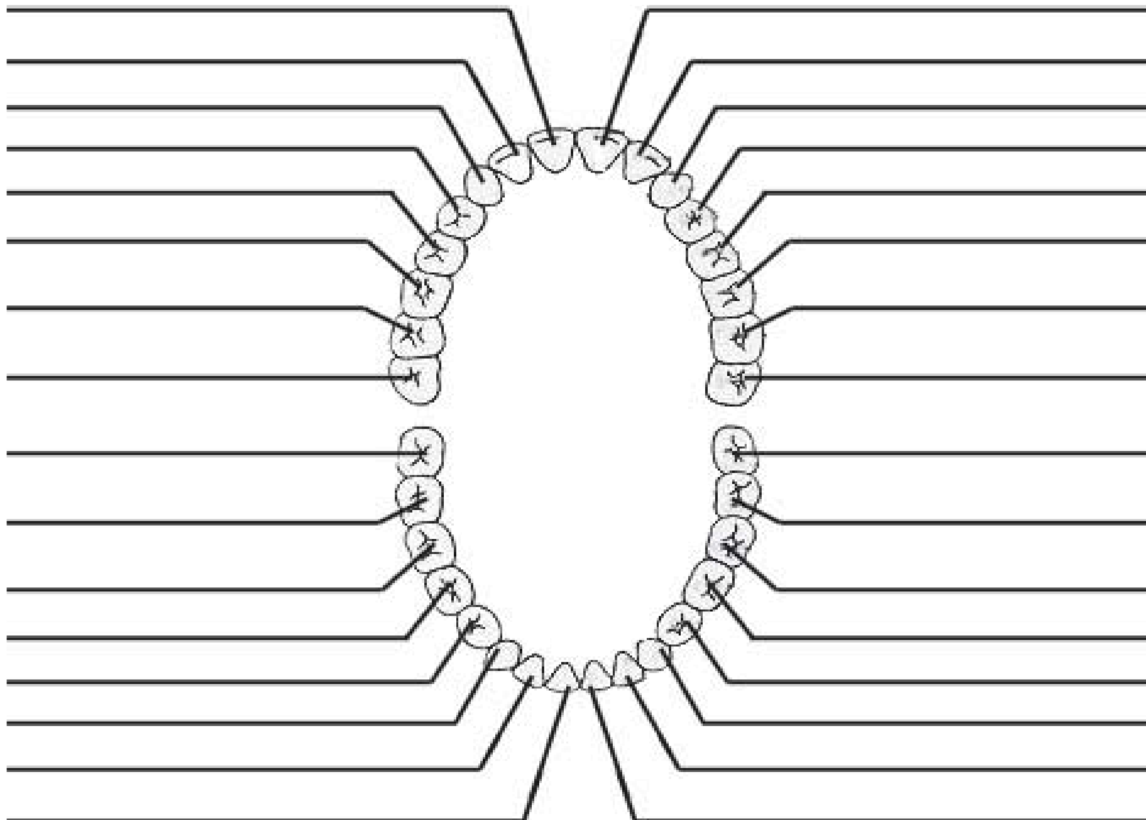
Do you require dental work at the moment? YES / NO ___________________________________

Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22."

Please use the following descriptors:

Silver filling Composite filling Gold crown Root canal Post (in root canal)
Bridge *(circle teeth)* Full denture Extracted tooth Partial denture

RIGHT LEFT



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