CLIENT HEALTH EVALUATION

Please complete all sections in detail and bring along to your appointment.

Personal Detail

Name: _____ Date: _____

Phone: _____ Email: _____

Address: _____

D.O.B._____ Age: _____ Weight: _____ kg Height: _____cm

Current Occupation: _____

Hobbies: _____

Overseas Travel in last 10 years: _____

_____

Pets: _____

Who referred you? _____

Top 3 Main health concerns / reason for appointment (in order of urgency)

	Practitioner Notes
1. _____	
When did this start? _____	
2. _____	
When did this start? _____	
3. _____	
When did this start? _____	

Other health concerns: _____

_____

_____

_____

What do you think might be the underlying cause/s of your health concerns?

_____

_____

_____

_____

Family History of Allergies or major dis-ease

Mother: _____

Mum's mother: _____

Mum's father: _____

Father: _____

Dad's mother: _____

Dad's father: _____

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CLIENT HEALTH EVALUATION

Client History

Please provide a brief but complete time-line from birth up to today of all major illness, infections, surgery and physical and/or emotional traumas in your life. The scar chart may assist.

(Example: Birth – complications, 3yo – bitten by a dog – still have nightmares, 5yo – Gran died, 8yo- Chickenpox, 11yo - moving home, 14yo broken collarbone, 17yo Glandular Fever, 28yo - surgery)

	Practitioner Notes

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CLIENT HEALTH EVALUATION

Current Prescription medications: (How much? How often?)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Vitamins/ minerals/ supplements/ herbs: (How much? How often?)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

_____

_____

What time do you usually go to sleep?_____Hours of undisturbed sleep per night?_____

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?

Do you strain? YES / NO

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

Any 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?_____

_____

Do you exercise? YES / NO (specify) _____

_____

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

Near electrical equipment for such as TV, mobile phone, 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

Immunisations / Vaccinations: (Please list all received)

_____

_____

_____

Have you taken or had **injections** of? cortisone YES / NO cytostatics 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)

_____

Contact with **pesticides or herbicides** or lived near crop spraying, farms, factories or mines? YES / NO (specify)

_____

_____

Known environmental allergies or reactions to medications?

_____

Women Only:

Are you pregnant? _____ Are you breast-feeding? _____

Are you or have you ever been on The Pill? _____ How Long? _____

Other Method of contraception:_____How long? _____

If you have been pregnant, briefly describe each pregnancy and birth:

_____

_____

_____

_____

Do you have monthly periods?_____ Are your monthly periods regular? _____

How many days is your cycle? _____ Number of days of your menstrual flow?_____

Which is your heaviest flow day/s? _____ Are you going through menopause?_____

Have your periods stopped? _____ When?_____

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? _____

_____

_____

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CLIENT HEALTH EVALUATION

Diet

List all foods that you are specifically excluding and say why *(eg. Peanuts – allergy, Gluten – bloating, Dairy – headaches etc)*

_____
_____
_____
_____
_____
_____
_____
_____

List any foods that you crave.

_____

Please provide a <u>detailed description</u> of all the foods you may normally consume in a 24hr period.

	Weekdays	**Weekends**
Breakfast		
Lunch		
Dinner		
Snacks		
Fluid *How much?* *Type?* Water Coffee Tea Soft drinks Milk		

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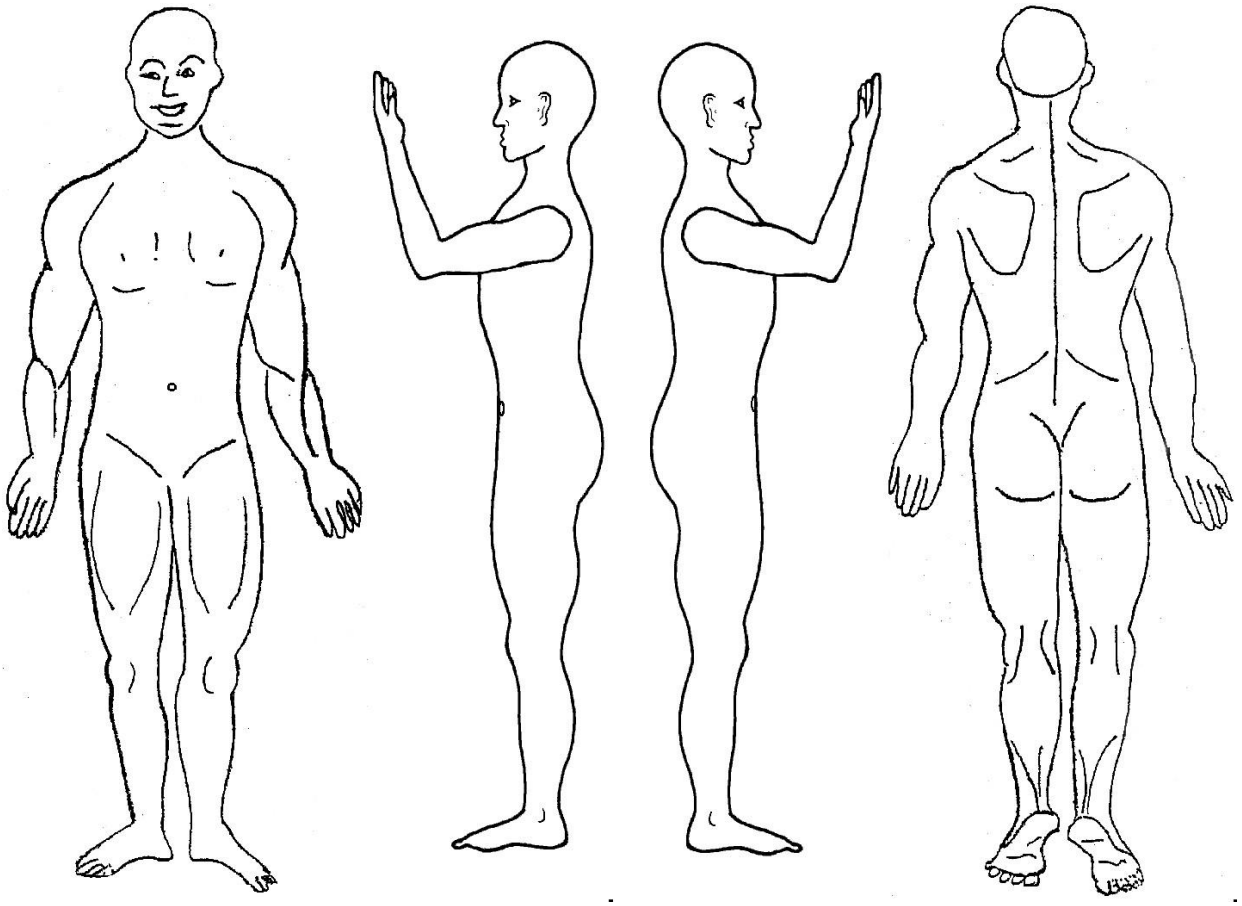
CLIENT HEALTH EVALUATION
Scar/Trauma Chart



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 ***red 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.

<u>Date of injury and type of injury</u>.

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.")

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CLIENT HEALTH EVALUATION
Dental History Chart

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

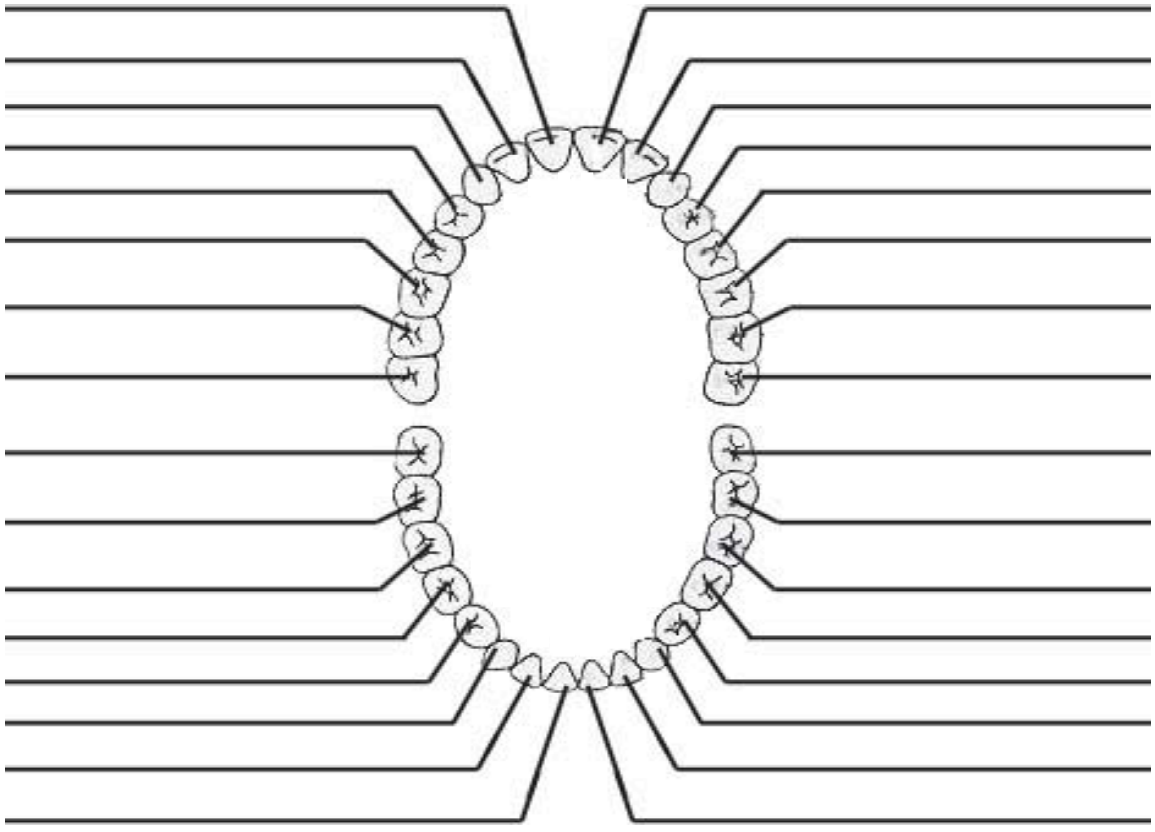
Do you require dental work at the moment? YES / NO _____

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



Practitioner Notes:

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