

fernskinclinic

Date

Name	Contact Number	
Street	Age	Weight
City/Post Code	Birth date	Sex
Occupation	Physician	Referred By
Other Concurrent Therapies		
Email Address		

Medical Information

What is your main health concern?

Onset/Duration

Do you have any medical conditions? Please list as well as all current medications, your daily dosage, and how long you have taken them:

Please list all allergies:

Please list all current supplements, your daily dosage, and how long you have taken them:

Is there anything you do that aggravates the present condition?

Is there anything you do that alleviates the present condition?

How many hours of sleep do you get on average? Do you wake feeling rested?

Lifestyle Information

Current Marital Status: Single Married Separated Divorced Other
How would you rate your current stress level? _____

How would you rate your overall health? Poor Fair Good Excellent

How would you rate your overall energy? Poor Fair Good Excellent

Do you Exercise? Y/N

Type/Duration _____

Hrs per week _____

Are you receiving any concurrent therapies at the moment? _____

What is your occupation? _____ Do you enjoy your job? Y/N

What are your health and lifestyle goals and expectations?

Medical History

Have you ever been hospitalised?

Please list any major injuries or surgeries you have had:

Family medical history - Please indicate family member :

Asthma	Autoimmune Disease	Cancer
Depression	Diabetes	Drug Abuse
Heart Disease	Hypertension	Kidney Disease
Lung Disease	Mental Illness	Osteoporosis
Stroke	Suicide	Thyroid Dysfunction
Other:		

Do you have any health concerns based on your familial history?

Diet

Do you follow a special diet? Y/N

Details:

Please describe your typical daily food intake:

Breakfast	
Lunch	
Dinner	
Snacks	

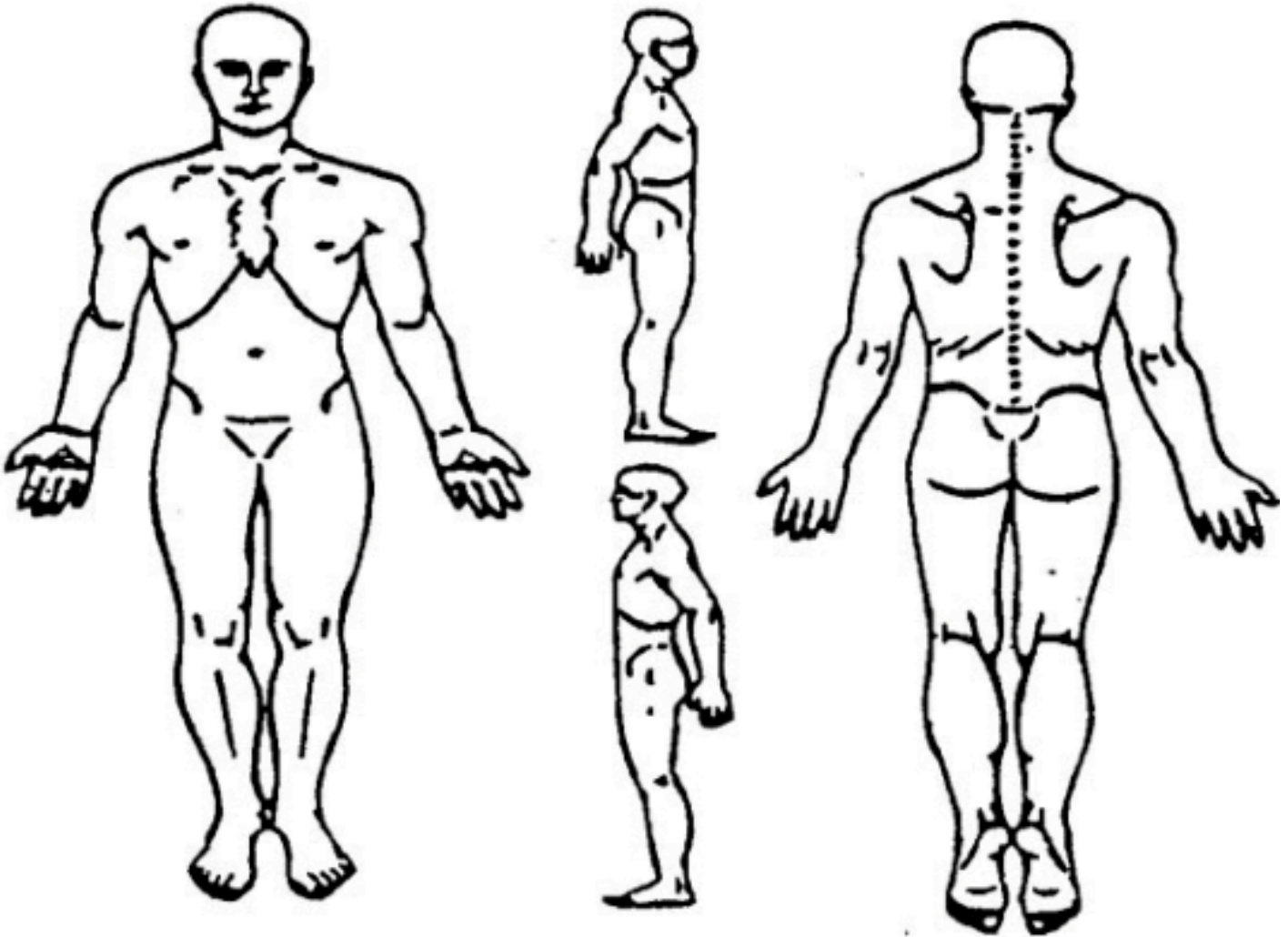
Are there any foods that you avoid:

Alcohol Intake: _____ Coffee: _____ Tea: _____ Pop/Fizzy Drinks: _____
Do you smoke? Y/N How many per day?

Health Details

General Symptoms	Cardiovascular	Respiratory
<p>history of headaches/migraines fever chills night sweats excessive sweating dizziness fainting weight gain allergy numbness/tingling in hands or feet mental/emotional issues chronic fatigue lethargy anemia</p>	<p>low blood pressure high blood pressure cardiovascular disease heart attack phlebitis varicose veins atherosclerosis swelling of hands/feet poor circulation irregular heartbeat shortness of breath chest pain heart palpitations</p>	<p>asthma emphysema chronic cough frequent lung infection bronchitis excessive phlegm difficulty breathing other:</p>
Eyes, Ears, Nose, & Throat	Gastrointestinal	Kidneys & Reproductive Health
<p>mercury fillings gum infections frequent colds tonsillitis frequent sore throat swollen glands glaucoma eye pain itchy eyes glue ear frequent ear infections nasal congestion sinusitis hay fever frequent nose bleeds mouth ulcers cold sores</p>	<p>excessive thirst excessive hunger food cravings belching gas/flatulence vomiting abdominal cramps constipation diarrhea intestinal bloating colon trouble hemorrhoids liver problems frequent nausea gallbladder problems jaundice colitis diverticulitis ulcers chron's disease ulcerative colitis parasites/worms</p>	<p>frequent urination cystitis interstitial cystitis painful urination blood in urine inability to urinate urinary incontinence kidney infection kidney stones STD - if yes, please list _____ _____</p> <p>treatment:</p>
Skin & Hair	Men	Women
<p>hives or allergy acne eczema psoriasis dryness sensitive skin pigmentation warts athletes foot fungal infection boils skin cancer rashes ulcerations vitiligo alopecia loss of hair male pattern baldness</p>	<p>prostate problems incomplete urination testicular pain cysts hernia discharge sores how many times do you wake during the night to urinate? _____</p>	<p>PMS frequent yeast infections/candida date of last menses: regular periods? Y/N cycle length: amenorrhoea dysmenorrhoea endometriosis PCOS fibroids fertility concerns miscarriage are you/could you be pregnant? Y/N pelvic inflammatory disease menopause</p>

Pain & Injury	Musculoskeletal & Joints	
please indicate on diagram: injury/breaks neck pain back pain shoulder pain chronic pain other:	muscle weakness foot trouble jaw pain swollen joints arthritis * if yes, please indicate affected joints:	hernia spasms/cramps osteoporosis tendonitis bursitis spinal curvature fibromyalgia



Psychological/Emotional Health:

- Anxiety
- Depression
- Insomnia
- Nervousness
- Panic Attacks
- Bi-Polar
- Suicidal thoughts
- Constant worry/paranoia

Have you ever been medicated for a psychological issues? Y/N If so, please provide details:

If there is any other relevant information pertaining to your health that was not covered in this intake please state it below or on the back of the form:

Informed Consent

Your ND will take a thorough case history and perform a relevant physical examination. It is very important that you inform your naturopath of any medical concerns or medication and supplements you may be taking. Please advise your ND if you are pregnant, suspect you are pregnant or if you are breast-feeding. As a patient you will receive information about your treatment, which may include diet and nutritional counselling, botanical medicine, acupuncture/skin needling, lifestyle counselling, and traditional chinese medicine. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By initialing next to each statement, you acknowledge your understanding of the associated risk and grant permission to proceed.

Possible side effects of naturopathic medical care include:

- Aggravation of pre-existing symptoms ____
- Allergic reactions to supplements or herbs ____
- Pain, bruising or injury from acupuncture/cupping ____
- Fainting from acupuncture needles/skin needling ____
- I have disclosed all medical conditions, allergies, and medications to my practitioner. Failure to do so could result in unforeseen side effects ____

With this knowledge, I voluntarily consent to Naturopathic care I intend this consent form to cover the entire course of treatment.

Patient/guardian:

Name (print):

Signature:

Practitioner:

Name (print):

Signature:

Date:

Thank you for your cooperation
All information provided on this form or during consultation will be kept strictly confidential