PATIENT HEALTH QUESTIONNAIRE

Name: ____ Date of birth: _________________

Home phone number: ___________________________ Mobile: ___________________________________

Address:____

Email address: ____

Emergency Contact name & number: ____

Do you have any children? YES / NO If yes, how many?____________________

Occupation: ____

Main health concerns / reason for attending clinic:

____

____

____

Previous medical history:

____

____

____

Previous doctors seen:

____

____

____

Current medications:

____

____

____

Current herbal / nutritional supplements:

____

____

____

NATMED
NATURAL MEDICINE CLINIC

Operations:

____

____

____

FAMILY history (parents/siblings/grandparents):

Heart disease   Blood pressure   Diabetes   Arthritis   Kidney disease

Depression   Thyroid problems   Cancer ______________________________

How did you first hear about NatMed?
(please tick appropriate box and provide details where applicable)

☐ Internet search   ☐ NatMed website   ☐ NatMed @ the Markets   ☐ Natural Therapy pages

☐ Referral by a friend (name:_______________)

☐ Referral by Professional (name:_________________)

☐ Sign outside / Walk by   ☐ Other (please provide details):_________________________________

Please fill in the following questionnaire and sign Cancellation Policy and Patient Consent.

This helps us get the most out of consultation with you.
Thank you for your time and patience.

SELECT THE NUMBER WHICH BEST DESCRIBES THE FREQUENCY OF YOUR SYMPTOMS.
IF YOU DO NOT KNOW THE ANSWER TO THE QUESTION, LEAVE IT BLANK.

0 = never, very rarely	1 = twice a week or less	2 = three to six times a week	3 = daily or several times a day, always

GASTROINTESTINAL

Antacid use	0 1 2 3
Heartburn, reflux with stress or eating	0 1 2 3
Often feel uncomfortable or unwell after meals	0 1 2 3
Tiredness after meals	0 1 2 3
Belching, burping and/or bloating after meals	0 1 2 3
Recent or past ulcer	YES / NO
Helicobacter pylori breath test positive	YES / NO
Indigestion/fullness lasts 2-4 hours after meals	0 1 2 3
Excessive gas, flatulence	0 1 2 3
Abdominal cramps, aches after meals	0 1 2 3
Specific foods/beverages aggravate indigestion	0 1 2 3
Roughage and fibre cause constipation	0 1 2 3
Known inflammation of small bowel eg. colitis	YES / NO
Known food sensitivities	YES / NO
Pain/burning/aching, 1-4 hours after meals	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Heartburn, especially when lying down or bending forward	0 1 2 3
Heartburn due to spicy and fatty foods, chocolate, chilli, alcohol or caffeine	0 1 2 3
Chronic fungal infections, thrush	YES / NO
Recent antibiotic use	YES / NO
Flatulence	0 1 2 3
Changeable bowel habits	0 1 2 3
Difficult bowel movement, constipation	0 1 2 3
How often do you use your bowels? ____________________	
Lower abdominal pain, cramping and/or spasms	0 1 2 3
Stool - hard, dry / poorly formed / smelly	0 1 2 3

Are you sensitive to:

Sulphites (wine, dried fruit, salad bar vegetables)	YES / NO
MSG (monosodium glutamate)	YES / NO
Food additives or colourings	YES / NO
Foods containing tyramine (red wine, cheese, bananas or chocolate)	YES / NO
Foods/beverages containing caffeine (coffee, tea, energy drinks)	YES / NO
Foods with onions or garlic	YES / NO
Chemicals (eg. fragrances, exhaust fumes or strong odours)	YES / NO
Do you feel ill after drinking small amounts of alcohol?	YES / NO
Are you allergic to antibiotics (eg. penicillin, tetracyclines)?	YES / NO
Do you regularly consume more than two alcoholic beverages per day?	YES / NO
Do you regularly consume more than three cups of coffee per day?	YES / NO
Do you regularly use paracetamol (Panadol)?	YES / NO

WELLNESS

Do you diet often	YES / NO
Do you skip meals	YES / NO
Do you exercise regularly	YES / NO
How often do you exercise?	__________
Are you regularly exposed to chemicals?	YES / NO
Are you vegetarian (no eggs or dairy)	YES / NO
Are you under excessive stress?	YES / NO
Do you smoke cigarettes?	YES / NO
How many per day?	_________
Do you drink alcohol regularly?	YES / NO
How many glasses per week?	_________

MOOD AND BEHAVIOUR

Do you feel stressed, nervous or tense	YES / NO
Do you feel irritable or oversensitive	YES / NO
Do you experience difficulty concentrating	YES / NO
Do you have coffee, tea, cigarettes, sugar or other stimulants as a ‘pick me up’	YES / NO
Do you experience worry or anxiety	YES / NO
Do you experience rapid heart beat or panic	YES / NO
Do you suffer from panic attacks	YES / NO
Do you feel depressed or often sad	YES / NO
Have you been medically treated for anxiety or depression eg. antidepressants	YES / NO
Do you have an overactive mind, worry too much	YES / NO

In the last 3 years, have you experienced:

Divorce or separation from partner	YES / NO
Major illness or death in family	YES / NO
Pregnancy, birth of child	YES / NO
Bankruptcy, financial loss	YES / NO
Moved house	YES / NO
Lost or started a new job	YES / NO
Do you drink caffeine or alcohol after dinner	YES / NO
Do you have difficulty falling asleep	YES / NO
Do you have you difficulty staying asleep	YES / NO
Early morning waking	0 1 2 3
Frequent waking	0 1 2 3
Waking up exhausted	0 1 2 3
Snoring, sleep apnoea	YES / NO

THYROID

Tired, sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Constipation	0 1 2 3
Dryness of skin and/or hair	0 1 2 3
Puffy face, hands and feet	0 1 2 3
Swollen, puffy upper eyelids on waking	0 1 2 3
Muscles weak, cramp or tremble	0 1 2 3
Slow mental processes, forgetfulness	0 1 2 3
Abdominal swelling, fluid retention	0 1 2 3
Gain weight easily, difficulty to lose	YES / NO
Outer third of eyebrow thinning	0 1 2 3
Thinning hair on scalp, face and genitals	0 1 2 3
Excessive menstrual bleeding	YES / NO

ADRENAL

Fatigue, tired all the time	0 1 2 3
Tired in morning, 'second wind' in evening	0 1 2 3
Afternoon energy 'slump'	0 1 2 3
Poor tolerance to stress	YES / NO
Poor tolerance to exercise	YES / NO
Slow recovery from infections	YES / NO
Changes in pigmentation, colour of skin	YES / NO
Food sensitivities	YES / NO
Environmental, pollutant sensitivities (eg. perfumes, exhaust fumes)	YES / NO
Increased allergic reactions	YES / NO
Progressive, mild fatigue after exertion or stress	0 1 2 3
General weakness	0 1 2 3
Blurred vision, dizzy when rising	0 1 2 3
Depression or anxiety	0 1 2 3
Rapid mood swings, irritable	0 1 2 3
Dark circles under the eyes	0 1 2 3
Craving for salt or salty foods	0 1 2 3
Decreased appetite	0 1 2 3

FEMALE

Before or during periods do you have:

Skin eruptions, pimples	YES / NO
Cravings for carbohydrates, sugar; binge eating	YES / NO
Headaches	YES / NO
Difficulty sleeping	YES / NO
Abdominal bloating	YES / NO
Breast tenderness, swelling	YES / NO
Breast lumps	YES / NO
Episodes of feeling depressed, anxious, nervous	YES / NO
Episodes of feeling angry, irritable, resentful	YES / NO
Episodes of feeling overwhelmed, emotional	YES / NO
Diarrhoea or constipation	YES / NO
Weight gain, water retention	YES / NO
Milk production (while not nursing)	YES / NO
Mid-cycle pain	YES / NO
Poor libido	0 1 2 3
Headache	0 1 2 3
Acne and/or oily skin	0 1 2 3
Aggressive feelings	0 1 2 3

Menstruation began after 16 years of age	YES / NO
Monthly abdominal pain without bleeding	YES / NO
History of vaginal infections, thrush	YES / NO
Irregular or delayed periods	YES / NO
Long menstrual cycles (more than every 32 days)	YES / NO
Short menstrual cycles (less than every 24 days)	YES / NO
Pain during periods is becoming worse	YES / NO
Pelvic pain, cramps	0 1 2 3
Lower abdominal pain, bloating	0 1 2 3
Lower backache	0 1 2 3
Scanty, light blood flow	YES / NO
Heavy blood flow	YES / NO
Clotting	YES / NO
Polycystic Ovarian Syndrome	YES / NO
Endometriosis (current or previous)	YES / NO
Fibroids (current or previous)	YES / NO
Ovarian cysts (current or previous)	YES / NO
Fertility issues (current or previous)	YES / NO
Miscarriage, pregnancy complications	YES / NO
Abnormal pap smear (current or previous)	YES / NO
Painful intercourse, bleeding after intercourse	YES / NO
Vaginal bleeding between periods	YES / NO
Hormonal birth control, 'the pill' (currently)	YES / NO

MENOPAUSE

Joint pain	0 1 2 3
Fatigue	0 1 2 3
Irregular menstrual cycle	YES / NO
Dry skin, hair and/or vagina	0 1 2 3
Poor libido	0 1 2 3
Mood swings, irritable	0 1 2 3
Depression, anxiety, nervousness	0 1 2 3
Craving for sweets, binge eating	0 1 2 3
Headaches or dizziness	0 1 2 3
Sudden hot flushes (day or night)	0 1 2 3
Unpredictable vaginal bleeding	0 1 2 3
Sleeping difficulties	0 1 2 3
Mental fogginess	0 1 2 3
Vaginal dryness, pain and/or itching	0 1 2 3

MALE (as per AMSS -- 1 = none to 5 = severe symptoms)

Decline in feeling of wellbeing	1 2 3 4 5
Joint pain & muscular aches	1 2 3 4 5
Excessive sweating	1 2 3 4 5
Sleep problems	1 2 3 4 5
Increased need for sleep, often feel tired	1 2 3 4 5
Irritability, moody, aggressive	1 2 3 4 5
Nervousness, restlessness	1 2 3 4 5
Anxiety, feeling panicky	1 2 3 4 5
Physical exhaustion, decreased activity	1 2 3 4 5
Decrease in muscular strength, weakness	1 2 3 4 5
Depressed mood, sad, lack of drive	1 2 3 4 5
Feeling you have ‘passed your peak	1 2 3 4 5
Feeling burnt out	1 2 3 4 5
Decrease in beard growth	1 2 3 4 5
Decreased in ability to perform sexually	1 2 3 4 5
Decrease in number of morning erections	1 2 3 4 5
Decrease in sexual desire/libido	1 2 3 4 5

CARDIOVASCULAR

Palpitations, extra beats, arrhythmias	0 1 2 3
Shortness of breath with rest or exertion	0 1 2 3
Dizziness on exertion	0 1 2 3
High blood pressure?	YES / NO
If yes, what medication are you on?	________
Chest tightness on stress or exertion	0 1 2 3
Previous angina attack, heart attack, stroke?	YES / NO
Known cardiac murmur or heart condition	YES / NO
High cholesterol, trigs or clotting problems?	YES / NO
Varicose veins	YES / NO
Previous deep vein thrombosis	YES / NO
Anticoagulation medication?	YES / NO
Pins and needles, numbness in hands or feet	0 1 2 3
Dizziness, ringing in ears	0 1 2 3
Fluid retention, ankle swelling	0 1 2 3
Muscle pain in calves or thighs when walking	0 1 2 3

RESPIRATORY

Do you use asthma medication or preventer?	YES / NO
Chest discomfort, pain on breathing or coughing	0 1 2 3
Sudden breathing difficulty, shortness of breath	0 1 2 3
Cough – dry	0 1 2 3
Cough – moist	0 1 2 3
Post nasal drip	0 1 2 3
Sputum thick, clear or yellow	0 1 2 3
Wheezing	0 1 2 3
Repeated chest infections	YES / NO
Flu symptoms longer than 5 days	YES / NO

IMMUNITY

Recent antibiotic use	YES / NO
Catch colds easily	YES / NO
Recurrent infections -ears, nose, throat, chest	YES / NO
Nasal congestion or mucous discharge	0 1 2 3
Sore throat or post-nasal drip	0 1 2 3
Cough with mucous	0 1 2 3
Cold sores, Herpes	YES / NO
Slow wound healing or recovery from infections	YES / NO
Mouth ulcers	0 1 2 3
Clear, watery discharge from nose, eyes	0 1 2 3
Sneezing	0 1 2 3
Specific foods worsen pain, inflammation, stiffness	YES / NO
Mouldy, damp environments trigger sickness	YES / NO
Post nasal drip with certain foods	YES / NO
Heart palpitations after eating certain foods	YES / NO
History of eczema, hives	YES / NO

KIDNEY/BLADDER

Mild lower back pain	0 1 2 3
Frequent urge to urinate, only small amount pass	0 1 2 3
Excessive and/or frequent urination	0 1 2 3
Burning with urination	0 1 2 3
Dripping after urination	0 1 2 3
Strong smelling urine	0 1 2 3

GLUCOSE TOLERANCE

Missing or delaying meals or fasting is associated with:

Sudden anxiety associated with hunger	YES / NO
Feeling shaky, jittery, tremors	YES / NO
Agitated, easily upset	YES / NO
Poor memory, forgetful, confused, disoriented	YES / NO
Dizziness, feel faint	YES / NO
Feel better after eating	YES / NO
Do you suffer from Diabetes?	YES / NO
Increased thirst and appetite	0 1 2 3
Dizziness when standing up from sitting position	0 1 2 3

MUSCULOSKELETAL

Generalised bone tenderness, achiness	0 1 2 3
Joint pain, stiffness especially back, hips, knees	0 1 2 3
Established bone loss (Osteoporosis)	0 1 2 3
Do you suffer from Arthritis?	YES / NO
Muscle tension, aches and pains	0 1 2 3
Headaches	0 1 2 3
Muscle cramps or spasm	0 1 2 3
Severe joint pain, redness, swelling, stiffness	0 1 2 3
History of gout episodes	YES / NO
Are you currently under the care of a chiropractor, osteopath, physiotherapist or massage therapist?	YES / NO

NATMED
NATURAL MEDICINE CLINIC

Section 1A – General detox	0	1	2	3	4	5
How much of the food you eat each week is 'spray-free' or organic?	All or most		Around half		Some	None
How often do you eat fruit? *(serve = handful)*	2 or more serves daily	1 serve daily		Weekly	Monthly	Never or rarely
How often do you eat vegetables?	2-4 serves daily	2-4 serves daily	Daily	Weekly	Monthly	Never or rarely
How often do you eat animal products? eg. dairy, eggs, poultry, red meat, fish	Never or rarely	Monthly	Weekly	Once daily	Twice daily	Most meals
Do you drink filtered water?	Always or mostly	Sometimes	Never or rarely			
How often do you eat tinned food?	Never or rarely	Monthly	Weekly	Daily		
How often do you eat 'junk' or fast food? eg. takeaway, deep fried, snack	Never or rarely	Monthly		Weekly		Daily
How often do you drink more than 4 standard alcoholic drinks in one session?	Never or rarely		Monthly	1-2 times weekly	3-6 times weekly	Daily
Do you use social or recreational drugs? eg. marijuana, ecstasy, speed etc	Never	Rarely		Monthly	Weekly	Daily
How many personal care products do you use? eg. soap, shampoo, conditioner, deodorant, moisturisers, makeup, perfumes	0-5 products daily		6-10 products daily		11-20 products daily	21+ more products daily
Do you feel unusually tired?	Never	Sometimes		Often		Always
Do you have any skin issues? eg. acne, eczema, rashes	None	Slight	Moderate		Severe	
Do you suffer from headaches or migraines?	Never or rarely			Monthly	Weekly	Daily
Do you suffer from allergies or asthma?	None	Slight		Moderate		Severe
TOTALS						

Section 1B - History	No Personal or Family history	Family history	Personal history (in past)	Personal history (current)
Cancer	0	2	7	10
Autoimmune disorders	0	3	5	10
Hormonal disorders	0	3	5	10
Type 2 Diabetes	0	2	4	8
Fibromyalgia or Chronic Fatigue	0	2	4	8
Heart Disease	0	1	3	5
TOTALS				

Section 2 - Gut	0	1	2	3	4	5
Do you get diarrhoea (loose and/or frequent stool)?	Rarely		Monthly		Weekly	Daily
Is there mucous or blood in your bowel motion?	Never		Rarely	Monthly	Weekly	Daily
Do you suffer from heartburn, burping, nausea or reflux requiring antacid medication?	Rarely	Monthly		Weekly	Daily	
Do you experience abdominal bloating or fullness?	Rarely	Monthly		Weekly	Daily	
Do you feel sensation of incomplete bowel emptying?	Rarely	Monthly	Weekly	Daily		
Do you experience constipation (less than 1 bowel motion a day)?	Rarely	Monthly	Weekly	Daily		
Been diagnosed with SIBO (small intestinal bacterial overgrowth)?	NO					YES
Have you been diagnosed with inflammatory bowel disease? eg. Ulcertative colitis, Crohns disease	NO					YES
Have you been diagnosed with irritable bowel?	NO					YES
Have you been diagnosed with a stomach or duodenal ulcer?	NO				YES	
Do you have any food allergies or sensitivities? eg. Coeliac, gluten intolerance, dairy intolerance	NO					YES
Do you suffer from thrush or Candida?	Never	Rarely		Monthly	Weekly	Daily
Do you take anti-inflammatory or pain relief medications?	Never	Rarely	Monthly		Weekly	Daily
Have you had a course of antibiotics in the last 5 years?	NO			1-3 courses		3+ courses
Have you had chemotherapy or radiotherapy in the last 5 years?	NO					YES
TOTALS						

Section 3 – Liver	0	1	2	3	4	5
Do you have liver or gallbladder disease? eg. gallstones, hepatitis, fatty liver	NO					YES
Are you or have you been exposed to heavy traffic, exhaust fumes and pollution? eg. live near main road, commuting	Rarely		Monthly	Weekly	Daily – few hrs	Daily - all day
Are you or have you been exposed to insecticides, pesticides or herbicides? eg. fly sprays, termite or flea treatments, work at golf course, orchard or farm	Rarely		Some-times		Weekly	Daily
Are you or have you been exposed to paints, solvents, glues, nail polish, hair dyes and similar products?	Rarely	Monthly		Weekly		Daily
Do you use cleaning products? eg. disinfectants, detergents, degreasers, polishes and similar products	Rarely	Monthly		Weekly		Daily
Do you consume food or drink from plastic or plastic-lined containers? eg. bottled water, disposable coffee cups, canned food, takeaway food containers	Rarely	Monthly	Weekly	Daily		
Do you have a new (less than 3 years) car, furniture or carpets?	NO				YES	
Have you lost a significant amount of weight?	NO				YES	
Do you have trouble losing weight?	NO			YES		
Are any of your symptoms worsened by exposure to substances eg. alcohol, cigarette smoke, perfumes and cleaning products?	NO	Slightly		Moderate		Severely
TOTALS						

Section 4 - Metals	0	1	2	3	4	5
Have you ever been diagnosed with heavy metal toxicity? eg. lead, mercury, cadmium, arsenic etc	NO					YES
Have you worked or do you work with metals? eg. plumber, gas fitter, foundry worker, welder; or in electroplating, leadlighting	NO		Some-times		Regular - hobby	Dail
Have you lived or do you live near a mine, industrial area, paint manufacturing, smelter, forge or foundry?	NO				YES	
Do you have difficulties thinking, adding up numbers, learning or reasoning or finding the right word to express yourself?	Never or rarely		Monthly		Weekly	Daily
Do you get numbness, tingling or weakness in parts of the body?	Never or rarely		Monthly	Daily	Weekly	Daily
Do you eat large deep see fish such as tuna, swordfish and shark (flake)?	NO	Rarely		Once or twice a month	Weekly	Several times a week
Have you been exposed to arsenic treatments such as anti-termite dusting, working with or burning treated timber?	NO					YES
Do you smoke tobacco? eg. cigarettes, cigars, pipes	Never	Past smoker		Social	Most days	Daily
Do you have or have you ever had mercury amalgam dental fillings (silver/grey, not white)?	NO			Since removed	1-3 fillings	3+ fillings
Have you every renovated an old house?	NO			YES		
TOTALS						

	1A - DETOX	1B	2 - GUT	3 - LIVER	4 - METALS	TOTAL SCORE
TOTALS						

Are you taking or recently taken any of the following medications (please circle):

Antacids	Laxatives	Thyroid	Cortisone / Anti-inflammatory
Hormones (HRT)	Oral contraceptive pill	Recreational drugs	Antidiabetic or Insulin
Aspirin / Paracetamol	Antibiotic / Antifungal	Chemotherapy	Radiation therapy
Sleeping tablets	Heart	Blood pressure	Antidepressants

DIET ***Please fill in what you would generally have for each meal***

Breakfast:
Morning snack:
Lunch:
Afternoon snack:
Dinner:
Beverages:
Other:

INFORMED CONSENT & PRIVACY CLEARANCE

I, *(please print your full name)* ______________________________________ have been advised by my practitioner of 'NatMed Natural Medicine Clinic' that he/she is not a medical doctor and that NatMed is not a medical practice. As such, he/she does not practice or prescribe allopathic medicine. I understand that he/she is a Naturopath. As such he/she seeks to activate and support the self-healing mechanism of the body. He/she utilises naturopathic medicine i.e. nutrition, herbal and/or homeopathic medicines and encourages preventative health care in the form of dietary, exercise and lifestyle management.

I give NatMed permission for my health history to be kept on file for the purpose of naturopathic care planning and prescribing.

I give NatMed permission to access past and current records from other health professionals I have or am seeing as appropriate.

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

Signed:____ Date: _________________________

NATMED CANCELLATION POLICY

NatMed now operates a cancellation list for appointments as we have a very high demand for consultations. This means that if you need an urgent appointment we will keep you on that list and offer you the first cancellation available.

In order to service all our clients better, we ask if you need to cancel your appointment that you give us 48 hours notice of cancellation.

Our practitioners make sure that they are here to service their appointments and when a client does not show up or give enough notice it means that other clients miss out on the opportunity to see them.

If we receive 48 hours notice, no fee will be charged for cancelled appointments. However, failure to give appropriate notice (48 hours) will result in a full consultation fee being charged to you.

I, *(please print your full name)* _________________________________ agree to NatMed's cancellation policy for appointments as above which states that cancellation of appointments with less than 48 hours notice will incur a consultation fee to be charged to me.

Signed:____ Date: _________________________