KARRINYUP
WELLNESS CENTRE
Chiropractic • Massage • Naturopathy

Naturopathic Adult Health History Form

Welcome to the Karrinyup Wellness Centre

Title: (Please circle) Mr/Mrs/Ms/Miss/Dr

Full Name: ..... Date of Birth: .....

Address: ..... Street ..... Suburb ..... Post Code

Phone: Home ..... Work ..... Mobile .....

Occupation: ..... Email Address: .....

GP Name: ..... Last Visit: .....

Are you in a health fund? Yes ☐ No ☐

Name of Fund: ..... Your number (eg 01 or 02) .....

Have you ever seen a Naturopath before? Yes ☐ No ☐ Last Visit? .....

Who may we thank or how did you hear about this clinic? .....

Purpose of this Appointment: What health opportunities brought you here today? .....

.....

.....

.....

Has anything recently changed or become worse? .....

.....

Have you had any stress in the last 5 years? (e.g. Deaths in the family, job loss, emotional stress, physical stress)? .....

Nutrition and Lifestyle

List any foods excluded from your diet: .....

.....

List any food cravings: .....

.....

List any foods that you dislike: .....

.....

Are you (please circle): Vegetarian / Vegan

If so, for how long: .....

Diet Diary

Please fill in below your diet from yesterday:

Breakfast: .....

Morning Tea: .....

Lunch: .....

Afternoon Tea: .....

Dinner: .....

Dessert: .....

Other: .....

Exercise

Type	Days per week (per exercise)	Minutes per session

Please indicate if you consume any of the following:

Alcohol ☐ Yes ☐ No Daily/Weekly Amount: ..... Type: .....

Tea ☐ Yes ☐ No Daily/Weekly Amount: ..... Type: .....

Coffee ☐ Yes ☐ No Daily/Weekly Amount: ..... Type: .....

Soft Drink ☐ Yes ☐ No Daily/Weekly Amount: ..... Type: .....

Chocolate ☐ Yes ☐ No Daily/Weekly Amount: ..... Type: .....

Lifestyle Questions: Please indicate if relevant:

Smoke Cigarettes ☐ Yes ☐ No Daily amount: ..... Strength: .....

Recreational drugs ☐ Yes ☐ No How long: ..... Type: .....

Medication & Supplements

Medication Name	Condition prescribed for	Who prescribed this medication? Since when?	When was the last time you saw the prescribing physician?	Would you like to stop taking this medication?

Surgeries and Accidents: .....

.....

.....

Allergies: .....

Drug allergies (penicillin, etc.): .....

Allergies to foods, pollens, etc.: .....

Women

Family History: Has a close relative (parent, child, sibling, or grandparent) had any of the following diseases?

Please tick:

☐ Allergies	☐ Diabetes	☐ High Blood Pressure
☐ Asthma	☐ Epilepsy	☐ High Cholesterol
☐ Arthritis	☐ Heart Stroke/Disease	☐ Thyroid Problems
☐ Anxiety/Depression	☐ Kidney disease	☐ Cancer/Growths
☐ Bleeding Disorder	☐ Multiple Sclerosis	☐ Other: .....

Medical History: Please tick the conditions that have affected you personally:

☐ Alcohol abuse	☐ Gall Bladder/Liver problems
☐ Allergies	☐ Gum/Teeth problems
☐ Anaemia	☐ Hay fever
☐ Arthritis	☐ Headaches
☐ Asthma	☐ Head Injury/Serious injury
☐ Bladder/Urinary problems	☐ Heart Disorders
☐ Bleeding problems	☐ Hepatitis
☐ Blood pressure problems/Stroke	☐ Hypoglycaemia
☐ Cancer	☐ Irritable bowel syndrome
☐ Crohns/Celiac Disease/Colitis	☐ Joint Problems
☐ Frequent colds, flu, sore throats	☐ Kidney Problems
☐ Diabetes	☐ Lactose intolerance
☐ Digestive disturbance	☐ Lung problems
☐ Ear problems	☐ Occupational exposure to Toxic substances
☐ Eating Disorders	☐ Parasites
☐ Oedema (Fluid retention)	☐ Depression/Anxiety/Panic attacks
☐ Epilepsy	☐ Skin Problems
☐ Eye problems	☐ Thyroid Problems
☐ Fatigue, Chronic	☐ Female gynaecological problems
☐ Other:	

Consent to Naturopathic Care

Naturopathic Medicine is a holistic approach to health care. Naturopaths assess the whole person, exploring the physical, mental, emotional and spiritual aspects of the individual. A number of different modalities are generally used in order to stimulate the body's inherent healing capacity. Modalities include diet, lifestyle counseling, clinical nutrition, herbal medicine and homeopathy.

I understand, the possible health risks associated with Naturopathic Medicine include but are not limited to; aggravation of pre-existing symptoms during the healing process, allergic reactions, mild gastrointestinal disturbances and headaches in response to supplements or herbs.

I have read and understand the above information. I intend this consent form to cover the entire course of care for my present condition and future condition(s). I understand that I am free to withdraw my consent and to discontinue my Naturopathic care at any time.

Signed ..... Date .....