artofhealing
naturopathic medicine

Adult Health Appraisal Questionnaire



Complete the following questionnaire.
Answer all relevant questions in as much detail as you can.

Today's Date: _____

Name: _____

Age: _____ DOB: _____ Sex: _____

Address: _____

_____

Phone (home): _____ (work): _____ (mobile): _____

Email: _____

Fax: _____

Occupation: _____

Single/Partner/Married: _____

Children: _____

Reason for naturopathic consultation:

List the symptoms or conditions you would like improved or treated in this consultation.

1. _____

2. _____

3. _____

4. _____

Current Medical History:

Have you been diagnosed with any of the following conditions?

- ☐ diabetes
- ☐ cancer
- ☐ irritable bowel
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ epilepsy
- ☐ bleeding disorder
- ☐ ulcerative colitis
- ☐ HIV/AIDS
- ☐ kidney disease
- ☐ heart condition
- ☐ thyroid condition
- ☐ liver disease
- ☐ osteoporosis
- ☐ cardiovascular disease

Other: _____

Give details and symptoms of the above conditions. (When were you diagnosed, frequency, what makes symptoms better or worse, treatments and were they successful?)

_____

_____

What medical tests or investigations have you had recently? (Include reason for test and results)

_____

_____

Do you have low iron levels? (When were you tested?)

_____

List any conventional medications that you are currently taking.

_____

_____

Are you allergic to anything? (eg. foods, medications, pollens, chemicals, moulds, animal hair)

_____

_____

List any vitamin or mineral supplements, herbs or homoeopathic remedies that you are currently taking. (Include dosages)

_____

_____

Are you currently seeing any other health practitioners?
(eg. acupuncturist, osteopath, chiropractor, physiotherapist, counsellor)

_____

_____

General Health:

I feel that I have not felt well since…… (eg. a particular event, illness, loss, trauma)

_____

_____

How many times a year do you get a cold or flu?

_____

_____

How often do you take antibiotics? (When was the last course taken?)

_____

_____

Do you suffer from any of the following?

- ☐ twitching eye
- ☐ poor memory
- ☐ poor wound healing
- ☐ muscular cramps where? _____
- ☐ muscle weakness where? _____
- ☐ feeling faint
- ☐ poor concentration
- ☐ dizziness
- ☐ tiredness and fatigue

Do you suffer from? ☐ headaches or ☐ migraines

Describe symptoms of your headache or migraine. (eg. frequency, duration, time of day what makes them better or worse – foods/coffee/time day/stress, describe the pain and location)

_____

_____

Energy levels:

On a scale of 1 to 10 indicate where your energy levels are currently:

(Low) 1☐.....2☐.....3☐.....4☐.....5☐.....6☐.....7☐.....8☐.....9☐.....10☐..... (High)

Do you feel that you have an energy slump at a particular time of the day or night? (Around what time?)

_____

_____

Do you feel tired and lethargic after eating?

_____

_____

How do you feel first thing of a morning?

_____

_____

Sleep:

Do you feel that you are getting a good night sleep?

_____

How many hours sleep a night do you get on average?

_____

Do you have any problems getting to sleep?
(Explain eg. worrying about things, mind won't switch off, stress and anxiety)

_____

Do you have any problems staying asleep?
(Explain eg. need to go to the toilet, panic attack, baby wakes you)

_____

Do you wake at any particular time? (What time?)

_____

Do you suffer from sleep apnea?

_____

Do you snore?

Do you get leg or feet cramps while you are sleeping?

Diet Dairy:

Fill out the following diet diary in as much detail as possible.
(Include portions, beverages and roughly what time you eat each meal)

What do you eat and drink during a normal day?

Breakfast:

Mid-morning snacks:

Lunch:

Afternoon snack:

Dinner:

Dessert:

Before bed snack:

Additional Dietary Information:

Are you a? ☐ vegetarian or ☐ vegan

Do you crave any foods in particular?

_____

List any other foods you eat regularly?

_____

How much water do you have daily?

_____

How many coffees do you have a day?

_____

How many teas do you have a day? (What type?)

_____

How many juices do you have a day?
(What type? eg. freshly squeezed, bottled, 100% juice, added sugar or fruit drink)

_____

How many soft drinks do you have a day? (What type?)

_____

Do you drink electrolyte sports drinks? (What type and how often?)

_____

How much alcohol do you have weekly? (What type?)

_____

Do you smoke cigarettes? (How many a day?)

_____

Do you take recreational drugs? (What type and how often?)

_____

Do you have problems eating any foods in particular?

_____

List any foods you dislike and won't eat?

_____

Do you have any of the following symptoms?

- ☐ often thirsty
- ☐ have trouble digesting fatty foods
- ☐ large appetite
- ☐ dry mouth
- ☐ small appetite
- ☐ always hungry

How many pieces of fruit do you eat a day?

_____

Do you eat vegetables daily?

_____

Do you add salt to your food?

_____

Do you add sugar, artificial sweeteners or honey to meals or beverages? (What type and daily amount?)

_____

Are you sensitive to?

- ☐ MSG
- ☐ caffeine
- ☐ garlic
- ☐ sugary foods
- ☐ sulphites (wine, dried fruits)
- ☐ onion
- ☐ alcohol
- ☐ spicy foods

Digestive Health:

Please indicate if you suffer from any of the following:

- ☐ gluten intolerance (Coeliac)
- ☐ wheat intolerance
- ☐ lactose intolerance
- ☐ milk protein allergy

Do you feel bloated after eating? (List foods)

_____

Do you get excessive flatulence after eating? (List foods)

_____

Do you burp often after eating? (List foods)

_____

Do you experience reflux, heartburn, or indigestion?
(Explain symptoms, what makes it worse eg. after a particular food)

_____

Do you experience abdominal pain or cramping?
(Explain eg. after a particular food, location of pain or cramping)

_____

Do you feel nauseous or vomit often? (What makes it worse or better?)

_____

How many times a day do you have a bowel movement?

_____

Do you suffer from constipation? (Explain eg. how often, after eating certain foods, when stressed)

_____

Do you have any pain or straining passing a stool?

_____

Do you suffer from diarrhoea? (Explain eg. how often, after eating certain foods, when stressed)

_____

Do you suffer from alternating constipation and diarrhoea? (Explain)

_____

Do you have haemorrhoids? (Explain eg. do they bleed, are they painful?)

_____

Describe your stool:

- ☐ loose
- ☐ undigested food particles
- ☐ floats
- ☐ dark brown colour
- ☐ watery
- ☐ contains mucus
- ☐ sinks
- ☐ black coloured
- ☐ hard
- ☐ contains blood
- ☐ light clay colour

Tongue diagnosis:

Look in the mirror at your tongue.

Do you have a white coating on your tongue?
(Is it thick or thin and what colour eg. white, cream, yellow, green, grey?)

_____

Do you have any cracks on your tongue? (Where?)

_____

Do you have an imprint of your teeth around the edge of your tongue?

_____

Is your tongue sore and red?

_____

Does your tongue tremble when you stick it out?

_____

Nail and Hair Health:

Do you have any white spots on your nails?

_____

Describe the health of your nails (eg. weak, split easily, soft, brittle, fungal infection)

_____

Do you have any problem with hair loss?

_____

Oral Health:

Do you suffer from any of the following?

- ☐ cold sores
- ☐ bleeding gums
- ☐ bad breath
- ☐ grind teeth
- ☐ ulcers
- ☐ teeth problems
- ☐ cracked lips, corners
- ☐ loss of taste and smell
- ☐ dry lips
- ☐ gingivitis
- ☐ cracked lips, centre

Other: _____

Give details and symptoms of the above conditions
(eg. frequency, what makes symptoms worse – stress, when run down)

_____

Ear and Eye Health:

Do you suffer from any of the following?

- ☐ recurrent ear infections
- ☐ hearing problems
- ☐ tinnitus (ringing ears)
- ☐ perforated ear drum

Other: _____

Give details and symptoms of the above condition.
(eg. frequency, what makes symptoms worse – stress)

_____

Do you suffer from any of the following?

- ☐ short sightedness
- ☐ glaucoma
- ☐ conjunctivitis
- ☐ red eyes
- ☐ dry eyes
- ☐ yellow sclera
- ☐ long sightedness
- ☐ cataracts
- ☐ styes
- ☐ itchy eyes
- ☐ watery eyes
- ☐ dark circles around eyes

Other: _____

Nose and Respiratory:

Do you suffer from any of the following?

- ☐ hay fever (allergic rhinitis) (seasonal or all year round?) _____
- ☐ recurring tonsillitis
- ☐ sinusitis
- ☐ bronchitis
- ☐ breathlessness on exertion
- ☐ nasal polyps
- ☐ asthma
- ☐ pneumonia
- ☐ wheezing
- ☐ frequent nose bleeds

Other: _____

Give details and symptoms of the conditions above.
(eg. frequency, causative factors, what makes it worse – pollens/a food/animal hair/time of year/stress)

_____

Do you currently have a respiratory infection? (Explain)

_____

Do you have any of the following symptoms?

- ☐ congested, blocked nose
- ☐ nasal catarrh clear
- ☐ nasal catarrh green
- ☐ nasal catarrh thin and watery
- ☐ sore throat
- ☐ red, swollen tonsils
- ☐ aching muscles
- ☐ cough describe (eg. hard, dry, wet, ticklish) _____
- ☐ productive cough (cough up sputum)
- ☐ unproductive cough (no sputum)
- ☐ runny nose, like a tap
- ☐ nasal catarrh yellow
- ☐ nasal catarrh thick and ropy
- ☐ nasal catarrh burns
- ☐ swollen glands
- ☐ fever
- ☐ frequent sneezing

Other:_____

Cardiovascular Health:

Do you suffer from any of the following conditions?

- ☐ High blood pressure (what was your last reading & when?) _____
- ☐ Low blood pressure (what was your last reading & when?) _____
- ☐ High cholesterol (what was your last reading & when?) _____
- ☐ chest pain
- ☐ heart palpitations
- ☐ bruise easily
- ☐ varicose veins
- ☐ cold hands and feet
- ☐ swollen feet or ankles
- ☐ palpitations on exertion

What is your blood type?

_____

Are you generally a hot or cold person?

_____

Do you get fluid retention? (Where?)

_____

Do you sweat excessively? (Where?)

_____

Do you get night sweats?

_____

Urinary System Health:

Do you suffer from recurrent urinary tract infections?
(Explain eg. how often, symptoms, when was your last UTI, usual treatment?)

_____

Describe your urine:

- ☐ clear colour
- ☐ offensive smell
- ☐ dark yellow colour
- ☐ contains blood

Do you have any of the following symptoms?

- ☐ urinary incontinence
- ☐ pain urinating
- ☐ incomplete urination
- ☐ urine leakage when cough
- ☐ frequent urination
- ☐ difficulty urinating
- ☐ sudden urgency to urinate

Describe the above symptoms.

_____

FEMALE Reproductive Health:

Do you take the contraceptive pill? (How long have you been on the pill and which one do you take?)

_____

Do you have vaginal thrush /candida? (How often do you get thrush? Describe symptoms.)

_____

Do you have any of the following symptoms?

- ☐ vaginal discharge, cottage cheese like
- ☐ vaginal discharge, offensive after sex
- ☐ external genitalia, itchy
- ☐ painful sex
- ☐ vaginal discharge, fishy odour
- ☐ vaginal discharge, green
- ☐ external genitalia, burning and raw feeling
- ☐ low libido

Do you suffer from any of the following conditions?

☐ endometriosis ☐ fibroids ☐ poly cystic ovaries ☐ polyps ☐ breast lumps

Give details and symptoms of the condition above. (eg. when was it diagnosed, treatment)

_____

Do you have genital herpes? (How often do you get flare ups?)

_____

Do you have any other sexually transmitted diseases?
(List – include symptoms and when did you contract STD)

_____

Preconception Care:

Are you planning on falling pregnant in the next 6 months?

Have you been having difficulty falling pregnant? (How long have you been trying?)

Would you like help with a preconception health plan?

Pregnancy Health:

Are you pregnant at the moment? (How many weeks?)

Is this your first pregnancy?

Have you had any problems with past pregnancies?
(eg. miscarriage, gestational diabetes, ectopic pregnancy, pre-eclampsia)

Have you had any spotting? (Explain)

Do you have morning sickness? (What makes it better or worse?)

Do you have any of the following pregnancy related conditions?

☐ gestational diabetes ☐ pre-eclampsia / toxaemia

List any other symptoms associated with your pregnancy that you are concerned about?

Postnatal Health:

Have you recently had a baby? (When?)

Did you have a vaginal delivery or Caesarean?

Were there any complications or trauma during the birth? (Explain)

_____

How has your recovery been after the birth?

_____

Are you currently breastfeeding, and if so have you had any difficulties? (Explain)

_____

Are you suffering from any of the following?

- ☐ mastitis
- ☐ bleeding nipples
- ☐ low milk supply
- ☐ nipple thrush
- ☐ breast red and hot
- ☐ pain when breastfeeding
- ☐ sore, cracked nipples
- ☐ breast abscess
- ☐ breast engorgement
- ☐ blocked milk ducts

Other: _____

Describe the symptoms above in detail.

_____

Menstrual cycle:

Do you have regular periods? _____

How many days is your menstrual cycle? _____

How many days do you bleed for? _____

Do you get mid cycle bleeding? _____

Do you have heavy or light periods? _____

Do you get any clotting? _____

Do you have any of the following menstrual problems?

- ☐ absence of period
- ☐ painful periods
- ☐ irregular periods
- ☐ very heavy periods

Give details of the above condition:

_____

Do you suffer from any of the following PMT symptoms?

- ☐ sore breasts
- ☐ cramping
- ☐ mood swings
- ☐ cry a lot
- ☐ fluid retention
- ☐ irritability
- ☐ depressed
- ☐ sugar cravings

Other: _____

When do you get the above symptoms, before or during your period?

_____

Do you get period pain? (Before or during your period)

_____

What makes the pain better or worse?
(eg. pressure, hot water bottle, crunching over, stretching back, lying down, certain time day)

_____

When was your last pap smear and what was the result?

_____

Menopausal:

Are you?

- ☐ pre-menopausal
- ☐ menopausal
- ☐ post-menopausal

When was your last period?

_____

Are you on HRT or considering going on HRT?

_____

Explain your menopausal symptoms (eg. hot flushes, vaginal dryness, depression, dry skin)?
(Include frequency, duration and how long have you had the symptoms, what makes symptoms better or worse)

_____

Do you get any of the following symptoms associated with hot flushes?

- ☐ flush comes from within – out
- ☐ sweating
- ☐ redness
- ☐ night sweats
- ☐ flush comes from the lower body to upper
- ☐ anxiety
- ☐ shaking

Other: _____

MALE Reproductive Health:

Do you have any problems with prostate health? (Explain) _____

Do you have any difficulty sustaining an erection? _____

Do you suffer from premature ejaculation? _____

Do you have a low sperm count or poor sperm morphology? _____

Do you suffer from low libido? _____

Do you have genital herpes? (How often do you get flare ups?)

_____

Do you have any other sexually transmitted diseases?
(Describe symptoms and when you contracted STD?)

_____

Preconception Care:

Are you and your partner planning on falling pregnant in the next 6 months?

_____

Have you and your partner been having difficulty falling pregnant?
(How long have you been trying?)

_____

Would you like help with a preconception health plan?

_____

Skin Health:

Do you suffer from any of the following?

- ☐ eczema
- ☐ tinea
- ☐ warts
- ☐ dermatitis
- ☐ dandruff
- ☐ yellow skin
- ☐ acne
- ☐ white patches
- ☐ psoriasis
- ☐ itchy scalp
- ☐ skin cancer
- ☐ hives
- ☐ itchy skin on body
- ☐ small bumps on back of arms
- ☐ rash

Other: _____

Describe the symptoms above. (eg. what skin looks like, parts of body effected, how long you have you had it for, what makes it better or worse – heat/cold/creams/itching/rubbing/season).

_____

Is your skin dry or oily? _____

Musculoskeletal Health:

Do you suffer from any of the following conditions?

- ☐ arthritis
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ gout

Describe symptoms of the condition above and when you were diagnosed?
(Include joints affected, treatments and were they successful, what makes symptoms better or worse?)

_____

Do you have any other musculoskeletal problems? (Explain)

_____

Exercise and Fitness:

How often do you exercise and what type of exercise do you do?

_____

Where do you rate your fitness?
(Not fit) 1☐.....2☐.....3☐.....4☐.....5☐.....6☐.....7☐.....8☐.....9☐.....10☐.....(Very fit)

If you're an athlete please include your training schedule, details about energy levels during and after training, how well you recover and any other relevant information?

Weight:

Are you happy with your weight? (Do you feel you need to lose or gain weight?)

What is your weight and height?

Do you have a history of dieting? (Explain)

Have you ever suffered from an eating disorder? (Explain)

For athletes, do you need to lose body fat or put on muscle mass?

Emotional Health:

Would you say that you are a stressed, anxious person? (Explain what makes you feel this way)

Have you ever had a panic attack? (Explain eg. when, how often, symptoms and possible cause)

Indicate if you identify with any of the following emotions at the moment:

- ☐ sadness
- ☐ jealousy
- ☐ thoughts of suicide
- ☐ cry a lot
- ☐ lacking self confidence
- ☐ violent
- ☐ perfectionist
- ☐ depressed
- ☐ hyperactive
- ☐ like company, need to be around people
- ☐ guilt
- ☐ joyless/lack of interest
- ☐ worthless
- ☐ angry
- ☐ shyness
- ☐ argumentative
- ☐ competitive
- ☐ outgoing
- ☐ like to spend a lot of time on my own

Please explain how you are feeling emotionally at the moment?

_____

Explain if you suffer from any mental illness?
(eg. depression, bi polar, schizophrenia, obsessive compulsive disorder)

_____

Past Health History:

Have you suffered from any of the following childhood illnesses?

- ☐ chicken pox
- ☐ mumps
- ☐ whooping cough
- ☐ rubella
- ☐ scarlet fever
- ☐ measles
- ☐ glandular feve

As a child did you suffer from any recurring infections
(colds and flu, tonsillitis, ear infections, bronchitis)?

_____

Please list any other health events, including viruses, injuries, hospitalizations and operations in the time line below:

0-5 years:

_____

5-10 years:

_____

10-20 years:

_____

20-30 years:

_____

30-40 years:

_____

40-50 years:

_____

50-60 years:

_____

60+ years:

_____

Family Health History:

List any known family diseases or illnesses such as diabetes, cancer, heart disease or mental illness (depression, bi polar, schizophrenia)

_____

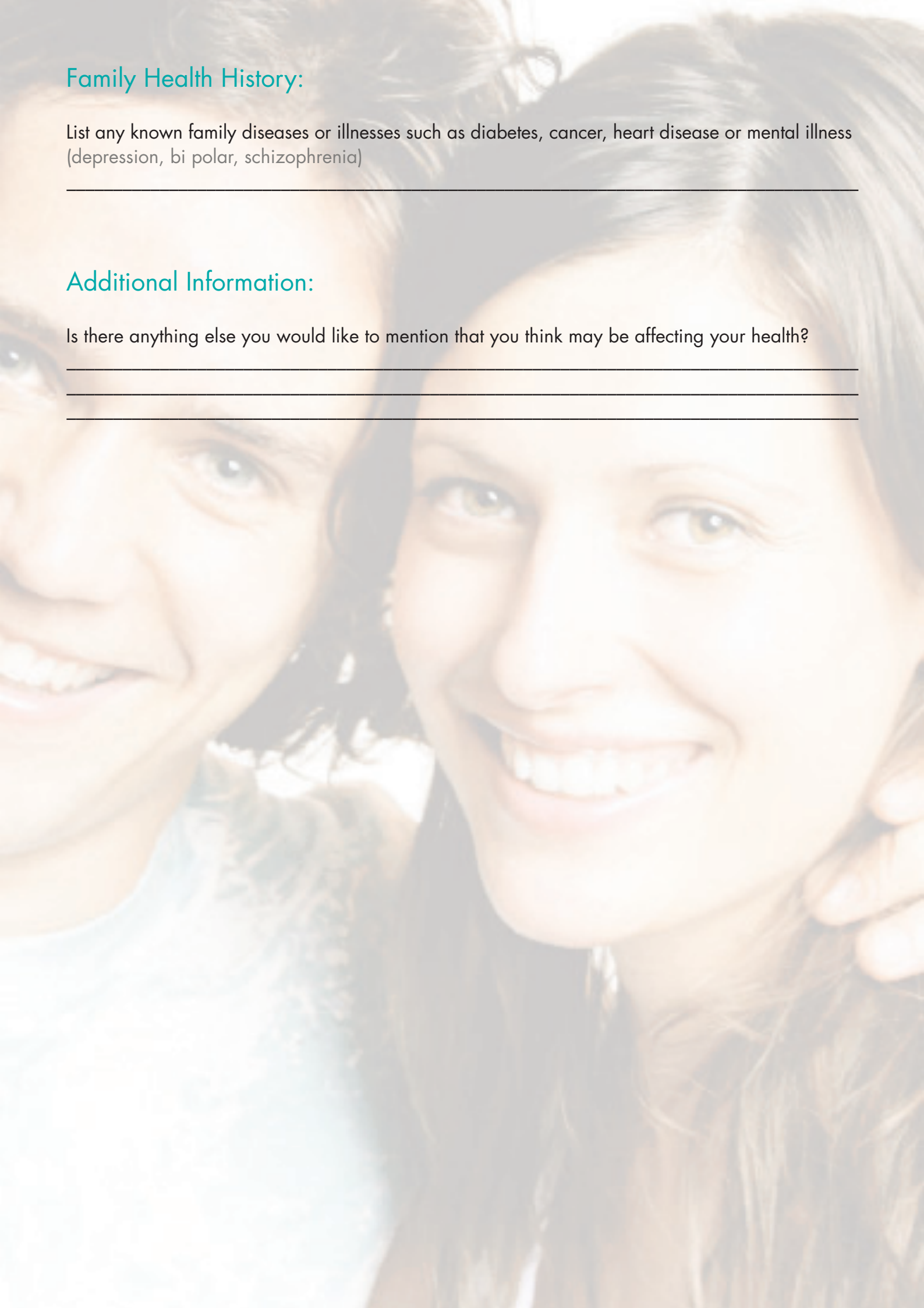
Additional Information:

Is there anything else you would like to mention that you think may be affecting your health?

_____

_____

_____



ONLINE NATUROPATHIC CONSULTATION CONSENT FORM

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths treat their patients holistically, taking into consideration their physical, mental and emotional aspects. Natural medicines are generally used in order to stimulate the body's inherent healing capacity. A number of different approaches are used by naturopaths such as dietary changes, nutritional supplements, herbs, homoeopathic remedies and lifestyle changes.

Naturopathic medicines are generally considered safe and side effect free. Although rare, negative reactions to these natural medicines can occur, such as an allergic reaction to a herb or an aggravation of pre-existing symptoms.

I understand that for a short period time I may experience worsening of symptoms or even new symptoms - this is called a healing crisis. Although unlikely, this is generally considered a positive sign and shows the body is making positive movement, and can signal the body is detoxifying.

Natural medicines should be used with caution when treating some conditions such as in pregnancy, diabetes, heart and liver disease. It is very important therefore that you inform your naturopathic practitioner immediately of any disease process that you are suffering from, or if you are pregnant, suspect you are pregnant or you are breastfeeding.

I understand that the interactions between herbs and prescribed drugs, are not yet well known, and that while unlikely could have an adverse reaction or experience a reduction or increase in the effect of other medications. If you are taking a prescribed medication and/or receiving other therapies – please advise your doctor of what treatment and supplements you may be receiving. Do not alter or cease medication without advising the prescribing practitioner. This includes psychological and counseling therapies.

I realise that physical examination, which may or may not be a necessary or crucial element of your health assessment, will not be possible during an online consultation.

I understand that a record will be kept of my personal health history. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that the naturopath will answer any questions I have to the best of their ability. I understand that results are not guaranteed. I do not expect the naturopath to be able to anticipate and explain all risks and complications. I will rely on them to exercise judgment during the course of the procedure which they feel at the time is in my best interests, based upon the facts then known.

☐ I have fully read and understand the above information and with this knowledge, I hereby consent to having an online naturopathic consultation with Lisa Guy.

Date: _____

SEND MY COMPLETED QUESTIONNAIRE

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