CONFIDENTIAL Application for Naturopathic Services
(This information will not be shared once submitted.)
North East Natural Health Centre
53 A Reid St Phone (03) 57229216
Email : nenaturalhealthcentre@gmail.com
Facebook : North East Natural Health Centre
Website: www.nenaturalhealthcentre.com

NAME: _____

ADDRESS: _____

_____ **POSTCODE**_____

PHONE: WORK (____) _____ **HOME (____)** _____

MOBILE _____

E-MAIL _____@_____

DATE OF BIRTH _____/_____/_____ **YOUR AGE** _____

Emergency Contact: Name_____ **Number**_____

OCCUPATION_____

HOW DID YOU FIND OUT ABOUT THIS CLINIC? _____

YOUR REASON FOR YOU INITIAL VISIT (BRIEF)

LIST ANY MEDICATION YOU ARE CURRENTLY TAKING (INCLUDE VITAMINS, THE PILL, ASTHMA MEDICATION, ANTIBIOTICS AND ALL PRESCRIPTION MEDICINES)

YOUR MEDICAL HISTORY (INCLUDE PAST OPERATIONS, ILLNESSES, DENTAL WORK)

YOUR AGE DETAILS

FAMILY HEALTH HISTORY – LIST ILLNESS THAT ARE IN YOUR FAMILY HERE…
MOTHER _____
MOTHERS PARENTS_____
FATHER _____
FATHERS PARENTS _____
Siblings_____
Children_____

HAVE YOU EVER HAD ANY SENSITIVITY REACTIONS TO ANY MEDICINES INCLUDING NATURAL REMEDIES? – N / Y, DETAILS
_____

A SAMPLE OF YOUR DAILY EATING ROUTINE

BREAKFAST_____
MID MORNING_____
LUNCH_____
MID AFTERNOON_____
DINNER_____
DRINKS_____
SNACKS_____

CRAVINGS _____
FOOD INTOLLERANCES/ ALLERGIES _____

RECREATIONAL DRUGS Y/ N ALCOHOL Y/ N CIGARETTES Y/N

Daily activities (include work, sport, music etc and time spent in each)
_____
_____
_____

Daily screen time hours (include TV, Computer, Phones etc)
Please circle
0 hours 1 hr 2-3 hrs 4+hrs

TICK WHICH STATEMENT APPLIES TO YOU AND YOUR HEALTH GOALS
(TICK MORE THAN ONE IF APPROPRIATE)

SHORT TERM FOCUS…
I AM ONLY HERE TO FIX MY CURRENT DISCOMFORT OR COMPLAINT _____
I WISH TO GET HEALTHIER BUT DON'T WANT ANY ADVICE FOR LONG TERM WELLBEING___

LONG TERM FOCUS …
I WANT TO BE HEALTHY NOW AND ALSO LEARN HOW TO STAY WELL FOR THE LONG TERM ___
I BELIEVE I AM WELL ALREADY AND AM JUST WANTING TO IMPROVE EVEN MORE___

SOMEONE SUGGESTED YOU NEEDED TO COME…
I AM HERE AGAINST MY OWN WISHES____
I DON'T KNOW WHY I AM ATTENDING THE CENTRE____

YOUR OVERALL HEALTH APPRAISAL QUESTIONAIRE

WHICH OF THE FOLLOWING APPLY TO YOU NOW? (CIRCLE THE ONES THAT APPLY)

Digestive	Bloating belching	discomfort	heartburn/reflux	gas/wind
	Fullness hunger	anemia	headaches near forehead	nausea
	Diarrhea	gut allergies	less than one stool daily	gall stones
	Vomiting	irritable bowels	blood in stool	anal itch
Skin / Nails	Excessively dry skin	irritation	eczema	psoriasis
	Melanoma	skin cancers	fungus/tinea	acne
	Other_____			
Respiratory	Cough	chest cold	difficulty breathing	mucous
	Bronchitis	asthma	shortness of breath	croup
Immune	Frequent colds	allergies	skin irritation	hayfever
	Swollen glands	itching	sinus infection	
	Infection present	low immunity	cancer past or present	
Muscles	Pains	spasms	joint pains	feet pain
	Back pain	tight muscles	neck/shoulder pain	aches
	Currently undertaking spinal musculoskeletal care? Y / N			
Urinary	Bladder weakness	frequent urine	urinary infection	
	Strong smelling urine	dark urine	urine flow is poor	
Males only	Prostate problem	low libido	erectile problems	
	Infection	groin rash	hernia	
Females only	Menopause	flushes	irritability	
	Low libido	sweating	very dry skin	
	Bleeding between cycle	irregular Periods	heavy periods	
	Thrush	clotted blood	change in moods	
	Breast tenderness	itch or rash	vaginal discharge	
	Pain/cramp	trying to fall pregnant		
	I have a diagnosed hormonal problem _____			
	I am pregnant	**I am breast feeding**		
Nerves	Stressed	moody	tired	
	Sleep problems	shift worker	hyperactive	
	Sadness	confusion	suicidal thoughts	
	Poor memory	anxious	wake unrefreshed	
Cardiovascular	Chest pain	heart problems	fainting	
	Fluttering/irregular heart	poor memory	cold hands	
	Confusion	heat rising to head		
General	Low energy	general unwell feeling		
	Headaches	eye discomfort		
	Generally I feel hot/ I feel cold			
	I am happy / unhappy with my current weight			**Thankyou.**

*****Once we start your treatment plan we ask that you do not self prescribe any natural medicines and that you inform us should your medical prescription change during the course of treatment. This is to ensure that there are no drug/herb interactions and to allow your treatment plan to work to its best potential.**

SIGNATURE: **DATE:**