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CLIENT DETAILS

CLIENT CONSULTATION FORM

Naturopathy

Client Name: ____

Date: _____/_____/20_____

Name: ____

Address: ____

City/Suburb: ______________________________________ Post Code: _______________

Phone: (home) ______________________________ (mobile) _____________________________

Email: ____@______________________________

Date of Birth: ____________________ Gender *(please circle)*: Male Female

Marital Status: _______________________________________ No. of Children: _____________

Occupation: ____

Height: ___________________ Weight: ___________________ BMI: ____________________

Waist: ____________________ Wrist: ____________________ BP: _____________________

Emergency Contact (Name and Phone): ____

____

Private Health Insurance________________________

____

____

Reason for Visit: ____

GENERAL HEALTH

____

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Please be assured that any information provided in this form is kept strictly confidential. No information will be shared with a third party without your knowledge and permission.

Current medical conditions: ____

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Past medical conditions: ____

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Family medical history (include main genetic or inherited weaknesses): ________________

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Are you currently taking any Medication (including contraception) or Supplements (including natural)? If so, please specify:

Have you had any operations (both minor and major)? If so, please specify:

Have you experienced any traumas (past or present/physical or psychological)? If so, please specify:

Vaccination history (from childhood to present):

Known Allergies or Sensitivities: ____

Name and Contact Details of Primary Health Care Provider e.g. GP: ______________________

CLIENT ANALYSIS

PLEASE SEND A PHOTO OF ANY AREAS OF MAJOR CONCERN.

OVERALL CONDITION OF…

Skin: ____________________________________

Hair: ____________________________________

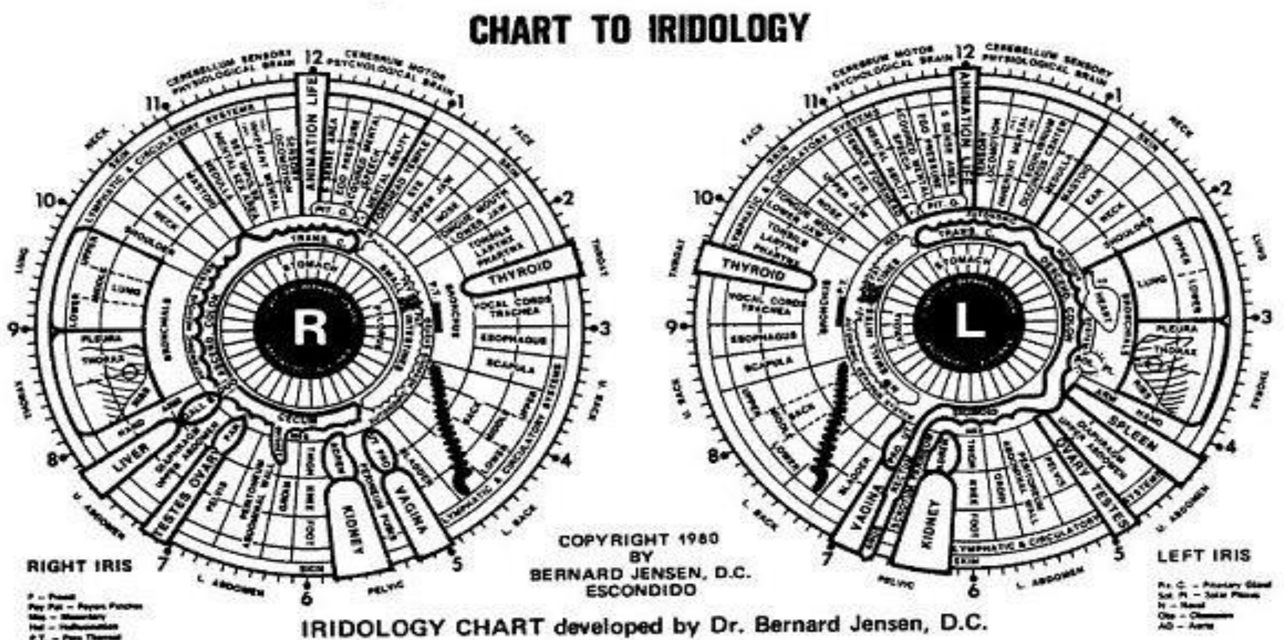
Nails: ____________________________________

Tongue: ____________________________________

Breath/odours: ______________________________

Practitioner Notes:

Please send a photo of the iris, if you wish an Iridology assessment.



IRIS ANALYSIS:

Constitution: ______________________________

Colour: ____________________________________

Pupil: _____________________________________

Stomach zone: ______________________________

ANW: ______________________________________

Lesions: ____________________________________

Nerve rings: _________________________________

Sclera: _____________________________________

Practitioner Notes:

Practitioner Notes:

BODY SYSTEMS ANALYSIS

Scale: 1 (Poor) - 10 (High)

Nervous system:

Headaches: ______________________________

Vision: ______________________________

Hearing: ______________________________

Smell: ______________________________

Taste: ______________________________

Loss of sensation: ______________________________

Concentration:______________________________

Memory: ______________________________

Tremors: ______________________________

Emotions: ______________________________

Gastrointestinal system:

Dental Status: ______________________________

Chewing: ______________________________

Reflux/heartburn: ______________________________

Vomiting: ______________________________

Dyspepsia: ______________________________

Nausea: ______________________________

Cramping/bloating: ______________________________

Tenderness: ______________________________

Food intolerances: ______________________________

Jaundice: ______________________________

Hepatitis: ______________________________

Bowel movements: ______________________________

____

Flatus: ______________________________

B12: ______________________________

Anaemia: ______________________________

Female reproductive system:

Age of menstruation: ____________________________

Cycle length: ___________________________________

Flow *(L,M,H)*: ________________________________

Clotting: _______________________________________

Symptoms: _____________________________________

Cramping: _____________________________________

Breast tenderness: ______________________________

Emotions: _____________________________________

Cravings: ______________________________________

Menopause: ____________________________________

Hot flushes: ____________________________________

Sweats: _______________________________________

Anxiety: ______________________________________

Onset Autoimmune Conditions: ___________________

____

Pregnancies: ____________________________________

Libido: ____

Other: ____

Male reproductive system:

Prostate: _______________________________________

Libido: ____

Other: ____

____

____

Respiratory system:

Cough: ____

Sputum: _______________________________________

Chest pain: _____________________________________

Breathing: ______________________________________

Dyspnoea: ______________________________________

Hayfever: ______________________________________

Asthma: _______________________________________

Nasal symptoms: _________________________________

Practitioner Notes:

Musculoskeletal system:

Pain: ____

Stiffness: ____________________________________

Aggravation: _________________________________

Range of motion: _____________________________

Weakness: ___________________________________

Swelling: ____________________________________

Other: _______________________________________

Cardiovascular system:

Cold hands/feet: ______________________________

Palpitations: _________________________________

Pain: ____

Blood clotting: _______________________________

Other: _______________________________________

Genito-urinary system:

Urination frequency: __________________________

Urination colour: _____________________________

Urination smell: ______________________________

Pain: ____

Blood: _______________________________________

Incontinence: _________________________________

Bladder infections: ____________________________

Other: _______________________________________

Endocrine:

Depression: __________________________________

Postural hypotension: _________________________

Weight gain: _________________________________

Sugar cravings: _______________________________

Mood Appraisal Assessment: ____________________

Recent Pathology Tests Received __________________

Pathology Tests to be Advised ______________________

Practitioner Notes:

PERSONAL DIET

Please list your general diet.

General Diet on the 7-Day Plan:

	BREAKFAST	LUNCH	DINNER	SNACK/LIQUIDS
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

NUTRITION & LIFESTYLE

Practitioner Notes:

What is your daily consumption of the following?

Water: ______________________________________

Coffee/tea/soft drink: ________________________

Tobacco: ___________________________________

Alcohol: ____________________________________

Recreational drugs: ___________________________

What is your daily exposure to the following?

Electro-magnetic radiation (computer/mobile): ___

____

____

____

Heavy metal exposure: ________________________

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Overseas travel (yearly basis): _________________

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Have you had any adverse reactions to specific foods?

____

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How long have these adverse reactions occurred?

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Describe your daily level of engagement in the following activities:

Low-level exercise e.g. walking: _________________

____

High-level exercise e.g. gym: ____________________

____

Hobbies: _______________________________________

____

On a scale from 1 – 10 (*1 being stress-free - 10 being absolutely stressful)*, how would you describe…

Your working life: ______________________________

Your home life: _________________________________

Relationships: _________________________________

Finances: _____________________________________

Health: _______________________________________

What are your current energy levels? _____________

____

Have they always been that way? Explain: ________

____

What are your current sleeping patterns? _________

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Have they always been that way? Explain: ________

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Practitioner Notes:

Have you experienced any lifestyle changes? E.g. loss of income, separation, moving house.

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Practitioner Notes:

Please sign and date to confirm that the information contained in this form accurately reflects your current health situation:

Sign ____ **Date:** _______________

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I, ____,
have read, understood and agreed with the above disclaimer.

Signature: ____

Date: ________________________

Practitioner Notes: