Jackson Health
NATUROPATHIC CLINIC

FERTILITY PROGRAM QUESTIONNAIRE

Please complete all questions as accurately as possible. All personal information is kept strictly confidential

Female Personal Details

DATE:___/___/___

Name:_____ Date of Birth:___/___/___Age___

Address:_____ Marital Status:_____

_____Post Code_____ No of Children:_____

Occupation:_____ Fax:_____

Phone Home:_____ Work:_____ Mobile:_____

Email _____

General Practitioner:_____ Health fund:_____

Female Health Details

Height:(mtrs)_____ Weight: (kgs)_____ BMI: (if known)_____

Do you currently attend any of the following Practitioners? (please give details)

Chiropractor☐ Naturopath☐ Osteopath☐ Reflexologist☐ Acupuncture☐

Other☐ :(please give details) _____

What is your current main health issue/s?_____

_____

Do you presently suffer any Chronic Illnesses? Yes☐ No☐

If yes, please give details of illness & how long you have suffered with this condition):

_____

_____

What aggravates your condition?_____

Do you have a family history of any Chronic Illnesses? Yes☐ No☐_____

If yes please give details_____

_____

In the past have you had any surgery or accidents? Yes☐ No☐

If yes please give details:_____

Do you suffer from any allergies or sensitivities to drugs? Yes ☐ No☐

If yes please give details:_____

Do you participate in any physical activities?

Never☐ Sometimes☐ 1-2 times wk☐ 3+times wk ☐

Do you smoke? Yes☐ No☐ If yes how many per day?_____

Do you drink alcohol? No ☐ Socially☐ 1-2 times wk☐ 3-4 times wk ☐5+ times wk☐

Do you drink coffee? Yes☐ No ☐

Sometimes ☐ 1-2 cups per day ☐ 3-4 cups per day☐ 5+ cups per day ☐

Current Medications and Supplements:_____

_____

Are you able to take medication containing alcohol? Yes☐ No☐

Female Reproductive Health

Are you or could you possibly be pregnant? Yes ☐ No ☐

How long have you been trying to conceive? _____ years _____ months

Have you had any previous conceptions? Yes ☐ No ☐

If yes, please give details for each one (eg: live birth, premature ,miscarriage, still birth,

termination, etc :_____

Do you have a known history of miscarriages? Yes ☐ No ☐ If yes, how many?_____

Are you currently seeing a Gynaecologist/fertility specialist? Yes ☐ No ☐

If yes what is your Dr's name:_____

Have you ever undergone any Medically Assisted Reproductive Procedures (eg IVF, Artificial

Insemination, Ovulation Induction)? Yes ☐ No ☐

If yes please give details:_____

Are you planning on undergoing any more procedures in the near future? Yes☐ No☐

If so, when approximately?_____

Do you experience pain or discomfort before, during or after your period?_____

Never☐ Sometimes☐ Most of the Time☐ Always☐

Do you get pain or discomfort around the middle of your cycle?

Never☐ Sometimes☐ Most of the Time☐ Always☐

Do you experience regular clotting during your menstrual period?

Never☐ Sometimes☐ Most of the Time☐ Always☐

Have you recently experienced any vaginal discharge? Yes☐
No☐

If yes what colour: _____ odour:_____

At present how many days on average is your menstrual cycle (ie how long between periods)_____

How many days on average does the bleeding last? (Do not include spotting)_____

What colour is the menstrual blood? Bright Red☐ Dark Brown☐ Pink☐ Red☐ Other☐

Have you recently experienced any midcycle spotting? Yes☐ No☐

Do you suffer any of the following menstrual symptoms?

PMT	Yes☐ No☐	Abdominal pain /cramping	Yes☐ No☐
Headaches	Yes☐ No☐	Cravings (chocolate, sugar etc)	Yes☐ No☐
Mood swings	Yes☐ No☐	Sore breasts	Yes☐ No☐
Backache	Yes☐ No☐	Fluid retention	Yes☐ No☐

Do you suffer any of the following?

Conditions		Conditions	
Diabetes	Yes☐ No☐	Heart Condition	Yes☐ No☐
Headaches	Yes☐ No☐	Migraines	Yes☐ No☐
Asthma	Yes☐ No☐	Hyperglycaemia	Yes☐ No☐
Bronchitis	Yes☐ No☐	Lung Problems	Yes☐ No☐
Coughs	Yes☐ No☐	Recurrent Cold's/Flu's	Yes☐ No☐
Arthritis	Yes☐ No☐	Pins & Needles	Yes☐ No☐
Numbness	Yes☐ No☐	Cold Hands & Feet	Yes☐ No☐
Ulcers	Yes☐ No☐	Nervous Tension	Yes☐ No☐
Allergies	Yes☐ No☐	Low Blood Pressure	Yes☐ No☐
Depression	Yes☐ No☐	Insomnia	Yes☐ No☐
Cystitis	Yes☐ No☐	Kidney Problems	Yes☐ No☐
Dizziness	Yes☐ No☐	Urinary Problems	Yes☐ No☐
Itching	Yes☐ No☐	Skin Problems/Rashes	Yes☐ No☐
Overweight	Yes☐ No☐	Loss of Weight	Yes☐ No☐
Hair Loss	Yes☐ No☐	Fluid Retention	Yes☐ No☐
Fatigue	Yes☐ No☐	Blackouts	Yes☐ No☐
Epilepsy	Yes☐ No☐	Cravings	Yes☐ No☐
Sinus	Yes☐ No☐	Sore Throat/Tonsillitis	Yes☐ No☐
Constipation	Yes☐ No☐	Diarrhoea	Yes☐ No☐
Haemorrhoids	Yes☐ No☐	Vomiting/Nausea	Yes☐ No☐
Hernia	Yes☐ No☐	Varicose Veins	Yes☐ No☐
Cholesterol	Yes☐ No☐	Indigestion/Reflux	Yes☐ No☐

(Office use only)

Male Personal Details

Name: _____ Date of Birth:___/___/___Age:___

Address: _____ Marital Status:_____

_____Post Code_____ No of Children:_____

Occupation:_____ Fax:_____

Phone: Home:_____ Work:_____ Mobile:_____

Height:(mtrs)_____ Weight:(kgs)_____ BMI:_____(if known)

Male Reproductive Health

Semen Analysis: Yes☐ No☐

If yes give details:

Count: Low ☐ Average ☐ High☐ Number (if known)_____

Motility: Low ☐ Average ☐ High☐ Percentage (if known)_____

Morphology: (abnormality rate) Low ☐ Average☐ High☐ Percentage (if known)_____

Have you ever undergone any of the following medical examinations?

- Hormone assessment blood test? Yes☐ No☐
- Tested for sperm antibodies? Yes☐ No☐
- Thyroid function blood test? Yes☐ No☐
- Ultrasound or external varicocoele assessment? Yes☐ No☐

Have you or do you suffer from any of these conditions:

- Mumps since onset of puberty? Yes☐ No☐
- Testicular Disease or Injury? Yes☐ No☐
- Sexually transmitted diseases? Yes☐ No☐
- Undecended testes? Yes☐ No☐
- Genito-Urinary infections? Yes☐ No☐

How would you describe your libido/sex drive? Low ☐ Moderate ☐ High ☐

Have you undergone any medical treatment for reproductive disorders? Yes☐ No☐

If yes, please give details:_____

Any main health issues _____

_____

Current medication/Supplements:_____

_____

Do you suffer any of the following?

Conditions		Conditions	
Diabetes	Yes☐ No☐	Heart Condition	Yes☐ No☐
Headaches	Yes☐ No☐	Migraines	Yes☐ No☐
Asthma	Yes☐ No☐	Hyperglycaemia	Yes☐ No☐
Bronchitis	Yes☐ No☐	Lung Problems	Yes☐ No☐
Coughs	Yes☐ No☐	Recurrent Cold's/Flu's	Yes☐ No☐
Arthritis	Yes☐ No☐	Pins & Needles	Yes☐ No☐
Numbness	Yes☐ No☐	Cold Hands & Feet	Yes☐ No☐
Ulcers	Yes☐ No☐	Nervous Tension	Yes☐ No☐
Allergies	Yes☐ No☐	Low Blood Pressure	Yes☐ No☐
Depression	Yes☐ No☐	Insomnia	Yes☐ No☐
Cystitis	Yes☐ No☐	Kidney Problems	Yes☐ No☐
Dizziness	Yes☐ No☐	Urinary Problems	Yes☐ No☐
Itching	Yes☐ No☐	Skin Problems/Rashes	Yes☐ No☐
Overweight	Yes☐ No☐	Loss of Weight	Yes☐ No☐
Hair Loss	Yes☐ No☐	Fluid Retention	Yes☐ No☐
Fatigue	Yes☐ No☐	Blackouts	Yes☐ No☐
Epilepsy	Yes☐ No☐	Cravings	Yes☐ No☐
Sinus	Yes☐ No☐	Sore Throat/Tonsillitis	Yes☐ No☐
Constipation	Yes☐ No☐	Diarrhoea	Yes☐ No☐
Haemorrhoids	Yes☐ No☐	Vomiting/Nausea	Yes☐ No☐
Hernia	Yes☐ No☐	Varicose Veins	Yes☐ No☐
Cholesterol	Yes☐ No☐	Indigestion/Reflux	Yes☐ No☐

(Office use only)

How did you hear about our clinic?

Yellow Pages ☐ Internet ☐ Radio ☐ T.V ☐ Signage ☐ Magazines ☐

I was referred to the clinic by:_____

I prefer to be contacted by: Mobile ☐ E-mail ☐ Home No.☐ No preference ☐

Disclaimer

The information collected on this form and during any future consultations is gathered for the purpose of assessment, diagnosis and treatment of the client's condition by Naturopath Jason Jackson. All personal information collected in this document and during future consultations will be kept strictly confidential and be seen by our Practitioners and our Clinic Assistants when necessary. We respect your privacy and under no circumstances will give out any personal information to anybody without your consent.

Payment Details

Credit Card Number _____-_____-_____-_____ Expiry ___/____

Name_____

Cancellation policy

If you need to cancel or change your appointment time for any reason, we ask that you please give at least 24 hours notice ; otherwise a fee equivalent to 75 % of the consulatation fee may apply if we are unable to rebook your appointment. We understand that emergencies do come up and ask that you please make a reasonable effort to contact us (e.g. Phone, message, email, mobile number) to advise us of your inability to attend your appointment.

Declaration

I/We .....(Print Name) have read and understood the above consent form. The information I have provided is accurate to the best of my knowledge. I understand that it is my responsibility to inform Jason Jackson of any changes to my personal details or medical condition. I agree with the Cancellation policy stated above and acknowledge that my credit card may be charged a cancellation fee if I fail to give 24 hours notice prior to my appointment.

Signature Patient: ..... Date: .....

Signature Partner: ..... Date: .....