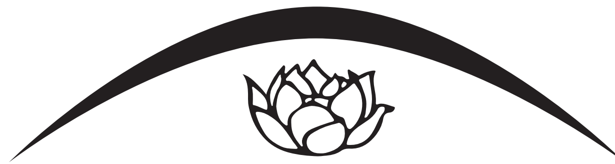

Jackson Health
NATUROPATHIC CLINIC

HEALTH QUESTIONNAIRE

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

Personal Details

TODAYS 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:__________________

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):

____

Do you have a family history of any Chronic Illnesses? Yes☐ No☐ (Parents or Siblings with health conditions):

If yes give details:____

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

If yes please give details:____

Do you suffer from any known **allergies** or **sensitivities** to drugs and/or foods? Yes☐ No☐

If yes please give details:____

Current Medications/Drugs: (please list below)

Medication/Supplement	Dosage	Reason for taking?	How long for?

Vitamins/Minerals/Herbs: (please list below)

Vitamin/Herbal Supplement	Dosage	Reason for taking?	How long for?

Do you drink coffee? Yes☐ No ☐ Sometimes ☐ 1-2 cups per day ☐ 3-4 cups per day ☐ 5+ cups per day ☐

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

Are you able to take medication containing alcohol? Yes☐ No☐
(NOTE: Most Herbal Tonics contain a small amount of alcohol as a preservative)

Do you smoke? Yes☐ No ☐ If yes, how many per day?_______ If yes, how long have you been smoking for?____________

Do you participate in any physical exercise? Yes☐ No ☐ If yes, how often:______________________

Please Tick any boxes that are currently applicable to the patient:

Digestive System

Reflux/Indigestion Yes ☐
Ulcers (Mouth/Gastric) Yes ☐
Nausea or Vomiting Yes ☐
Constipation Yes ☐
Diarrhoea Yes ☐
Bloating Yes ☐
Flatulence/Wind Yes ☐
Stomach Cramps or Pains Yes ☐
Cravings (Type:___________) Yes ☐
Hepatitis (Type:___________) Yes ☐
"Fatty" Liver Yes ☐
Gall Bladder (Stones, Disease, Removal) Yes ☐
Haemachromotosis Yes ☐

Nervous System

Anxiety Yes ☐
Depression/Low Mood Yes ☐
Low Motivation Yes ☐
Insomnia Yes ☐
Headaches Yes ☐
Migraines Yes ☐
Dizziness / Vertigo Yes ☐
Tinnitus (ringing in ears) Yes ☐
Fatigue Yes ☐
Epilepsy Yes ☐

Respiratory/Immune System

Asthma Yes ☐
Cough (Dry or Wet) Yes ☐
Lung Problems Yes ☐
Recurrent Colds or Flus Yes ☐
Hayfever/Allergies Yes ☐
Sinusitis Yes ☐
Sore Throat Yes ☐
Recurrent Infections Yes ☐
Viruses Yes ☐
(eg: Glandular Fever, Ross River, Cytomeg, Mycoplas, HIV etc.)

Reproductive/Renal System

Recurring Thrush or Discharge Yes ☐
Heavy Periods Yes ☐
Painful Periods Yes ☐
Irregular Cycles Yes ☐
Hirstuism (increased hair growth) Yes ☐
Kidney Issues Yes ☐
Sexually Transmitted Diseases Yes ☐
Urinary Tract Infection/Cystitis Yes ☐
Painful or Frequent Urination Yes ☐
Enlarged Prostate Yes ☐

Cardiovascular System

High Blood Pressure Yes ☐
Low Blood Pressure Yes ☐
Heart Palpitations Yes ☐
Pins & Needles Yes ☐
Cold hands and/or feet Yes ☐
Heart Condition Yes ☐
Stroke Yes ☐
Fluid Retention Yes ☐
Shortness of Breath Yes ☐

Other

Diabetes (Type 1 or Type 2) Yes ☐
Thyroid (Underactive or Overactive) Yes ☐
Hair Loss Yes ☐
Fatigue Yes ☐
Eczema or Psoriasis Yes ☐
Skin Rashes Yes ☐
Acne or Pimples Yes ☐
Arthritis / Joint Pains Yes ☐
Muscle Aches/Pains/Cramps Yes ☐
Overweight Yes ☐
Underweight Yes ☐

How did you hear about us? (Please tick)

❐**Yellow Pages** ❐**Website** ❐**Radio** ❐**Signage** ❐**Magazine** ❐**Word Of Mouth**

❐**Other** (please state):____

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

I was referred to the clinic by:____

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: .... - .... - .... - ....

Name: .... *Expiry:*....................... / ....

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 consultation 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..(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:.. *Date:*...

Welcome to Jackson Health Naturopath Clinic

Your Health is Our Priority

Jackson Health
NATUROPATHIC CLINIC