

NATUROPATHY HEALTH APPRAISAL

Name: _____ Occupation: _____

Please state briefly why you have come for a health consultation today. Please list symptoms of importance to you:

In naturopathic health care it is helpful to have a complete picture of you. Please assist by completing the following questionnaire.

FAMILY HISTORY Please tick if you or any member of your family has had any of the following conditions:

CONDITION	SELF	FAMILY	CONDITION	SELF	FAMILY
Allergies/Eczema			High blood pressure		
Thrombosis/Phlebitis			Asthma		
Low blood pressure			Depression		
Hay fever/sinusitis			Cancer		
Anxiety			Diabetes		
Thyroid disease			Psychological conditions		
Migraines/Headaches			Heart disease		
Alcoholism			Epilepsy		
Pregnancy			Digestive/Intestinal problems		
Urinary/Kidney problems			Hepatitis/HIV/AIDS		
Other			Skin conditions		
Cold hands/feet			Dislocations, breaks and fractures		
Obesity			Dizziness, blurred vision		
Joint pain, arthritis, rheumatism.			Menstrual problems		

MEDICATIONS AND SUPPLEMENTS

Are you currently on any medications? _____

Are you currently taking any herbal or vitamin/mineral supplements? _____

Have you had any illness or operations within the last 12 months _____

CURRENT MEDICAL CONDITIONS Please state briefly any current medical conditions and tick the boxes that apply below

- Allergies Bleeding disorder Epilepsy Heart condition Cancer
 Infection Diabetes Pacemaker Pregnancy

Please tick if you have any of the following:

IMMUNE	LIVER / GALLBLADDER	METABOLIC
Colds/Influenza	Hives	Fatigue
Allergies/Hay Fever	Itching	Weakness
Frequent Infections	Stools pale/clay coloured	Dry skin/brittle hair
Thrush	History of Jaundice, Hepatitis A, B or C	Weight gain
SKIN	URINARY	Sensitive to heat
Skin problems	Frequent urination	Sensitive to cold
Poor wound healing	Poor stream	Cold hands and feet
ENT	Dribbling urine after urination	Craving frequent snacks/sugar
Ear infections	Sudden, urgent need to urinate	Muscle cramps
Tonsillitis	Leakage with cough/strain	Migraine
Sinusitis	Getting up at night to urinate	MUSCULOSKELETAL
RESPIRATORY	Frequent bladder infections	Aches/pains
Cough	REPRODUCTIVE (MALE)	Joint pain
Wheeze	Poor beard/hair growth	Joint swelling
Breathlessness	Difficulty sustaining erection	Joint stiffness
CARDIOVASCULAR	Lack of sexual desire/interest	Headaches
Chest pains	Past sexually transmitted disease	NERVOUS SYSTEM
Palpitations	REPRODUCTIVE (FEMALE)	Tingling/numbness
Breathless with exertion	Cycle length (days)	Vertigo
Dizziness	Period length (days)	Poor balance
Ankle swelling	Miss periods?	Recent change in vision
Varicose veins	Pain with/before period	Morning headaches
Leg pain with exertion	Fluid retention with/before period	MENTAL
Cold feet	Heavy periods	Frequent sad feelings
Easy bruising	Hot flushes	Feelings of anxiety/panic
UPPER GASTROINTESTINAL	Vaginal dryness	Loss of interest/enjoyment
Indigestion	Recurrent thrush	Reduced/broken sleep
Belching/burping	History of sexually transmitted disease	Difficulty concentrating
Heartburn/Acid reflux	History of abnormal PAP smears	Change in appetite
Sense of fullness after food	Ovarian cysts/breast lumps	Pessimistic/guilty thoughts
Nausea/vomiting	Fibroids/Endometriosis	Thoughts/plans for suicide
Stomach pain	Excess facial hair/acne	
LOWER GASTROINTESTINAL	Milk production (not breast feeding)	
Lower abdominal pain/cramps	Lack of sexual desire/interest	
Excess gas/bloating		
Stools hard/dry		
Use laxatives		
Stools loose/watery		
Blood/mucus in stools		

LIFESTYLE Please answer Yes (Y) or No (N) to the following - stating how much

	Y/N	HOW MUCH?		Y/N	HOW MUCH?
Do you drink: Coffee			Do you smoke: Tobacco		
Tea			Cannabis		
Soft drinks			Do you consider yourself to be stressed?		Score 1-10
Fruit juice			Do you exercise regularly?		
Water			What type?		

DIET Please indicate your general diet

BREAKFAST:

MID-MORNING:

LUNCH:

SNACKS/DESSERTS:

EVENING MEAL:

What do you hope to gain from this treatment?

Is there any other information you wish to tell me that may be relevant to this treatment?

PATIENT INFORMATION

If you are taking 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 counselling therapies.

Signature: _____

Date: _____

INFORMED CONSENT FOR ELECTRODERMAL SCREENING

Signing this section indicates that you are voluntarily and knowingly undergoing a procedure referred to as computerised electro dermal screening. (C.E.D.S)

The procedure is totally non-invasive. (The skin is not punctured). This procedure includes the application of an electronic probe of five volts to measure skin resistance at selected acupuncture sites located on the hands and feet. It will then be determined as to which natural substance will be needed to re-establish proper balance to the body's chemistry.

Because the procedure involves only the measurement of changes in the meridian flow with a sensitive meter, it is completely safe. The only sensation that is usually felt is just the pressure of the electronic probe as it is pushed against the skin. The use of the computer makes the procedure extremely fast.

At no time will there be any implied and/or stated indication for any client to discontinue taking any medication as prescribed by his/her physician or discontinue care under the direction of any other physician. This procedure is not intended, implied, or stated to take the place of any conventional medical test and/or diagnostic procedure.

I have fully read and understand the above information, the elements of informed consent, my responsibilities and rights, and hereby consent to the participation in the electro-dermal screening procedure.

Signature: _____

Date: _____