36 McMasters Lane, Lancefield, VIC 3435
03 5429 1737

HEALTH QUESTIONNAIRE

Answering these questions in detail will assist me in giving the best possible care, and help with on-going research into the treatment of disease and restoration of health. All information will be held in the strictest confidence. This questionnaire is designed for a variety of health challenges, and therefore some areas may not be applicable to you. Please complete all sections relevant to you in great detail. If you can't remember all details, please give the information you can remember. Please read any instructions in *italics* carefully before answering questions.

PERSONAL CONTACT DETAILS:

Surname:_____

Given Names:_____

Address:_____

_____

State _____ Post/Zip Code _____ Country _____

Phone:_____ Mobile:_____

Email:_____ Skype ID: _____

Date of Birth: _____/_____/_____ Place of Birth (**town** & country):_____

Where did you spend your childhood (0-10)? _____

When did you move to Australia? (if applicable)_____

Marital Status:_____ Name of Spouse/Partner:_____

Occupation [if retired, please show previous occupation(s)] _____

_____

How did you find us? (tick all that apply): Website ☐ Facebook ☐ LinkedIn ☐

Referred (who?) ☐ _____ Other (define): _____

Please send completed, original hard copy (regardless of consult location) via <u>post only</u> (do Not email nor fax) to:

36 McMasters Lane, Lancefield, Victoria 3435, Australia
Telephone: 61 (03) 5429 1737
(*it's a good idea to keep a copy for yourself*)

DIAGNOSIS/MAIN CONDITION:

What is your disease diagnosis (if any)?_____

When were you first diagnosed?_____

Who was the doctor/practitioner who made the diagnosis?_____

Who is your current doctor/GP?_____

Who is your current specialist?_____

Do you see another naturopath? Who? _____

What symptoms prompted you to go to seek investigations/diagnosis?_____

_____

_____

_____

When did these symptoms first become noticeable to you? _____

_____

GENERAL HEALTH

Height_____ Weight _____ Blood Pressure (if known)_____

Are you allergic to anything (food, drugs, plants, insect bites, etc.)? Yes/No Please give details:

_____

_____

What other health conditions concern you now (eg. arthritis, hypertension, diabetes, etc.)? Please include everything, no matter how trivial it may seem. Please include the time when these health conditions first occurred.

_____

_____

_____

_____

Do you feel depressed some or all the time? Describe: _____

_____

_____

Do you smoke cigarettes? YES / NO How many per day?_____

How long have/had you been smoking?_____ When did you stop ?_____

Do you drink alcohol? YES / NO If so, how many drinks per day/week/month?_____

How many bowel motions do you have <u>every day</u>? (if this varies, explain) _____

Do you have diarrhoea and/or constipation? If so, which and how often?

_____

Please give details of any regular exercise you undertake:

_____

_____

Do you meditate or use any form of relaxation technique? Details:_____

_____

Do you sleep well? Describe:

_____

_____

<u>HEALTH HISTORY</u>

Please list all serious disorders you have had, including <u>childhood</u> <u>and adult</u> illnesses (e.g. mumps. measles, pleurisy, etc). If you are not certain if the disease is serious, please include it.

Disorder	**Age (approx.)**	**Disorder**	**Age (approx.)**

*Please list all **<u>surgical procedures</u>** and type of **<u>anaesthetic</u>**:*

Surgery	**When (approx.)**	**Anaesthetic (General/Local/Spinal/etc)**

Please give details of any accidents you have had (motor cars/trucks, work related, sporting, childhood) even if they seem irrelevant.

Accident	**When?**	**Injuries**

MEDICATIONS

*Please list below the medications you are **CURRENTLY** taking for **ALL** conditions, plus any **significant** medication taken over the past five (5) years. Include over-the-counter pharmaceutical medicine if taken regularly.*

Prescribed Medicines *(e.g. Cogentin, Sinemet Normison, Doxycycline)*	**Dose** *(e.g. 0.5 g, 20 mg, 100/25)*	**Times Taken** *(e.g. each morning with food; twice daily @ 8am & 6pm)*	**When Commenced** *(approx date as accurate as possible). Add end date if no longer taking.*

SUPPLEMENTS

*What supplements (vitamins, minerals, anti-oxidants, herbs, homeopathics, etc) are you now taking? Include tablets, capsules, powders, "super foods", "health juices". **Include** whether you take **with** or **without** food, etc. Add extra pages if required. ALL DETAILS ARE REQUIRED INCLUDING BRAND.*

Brand & Product Name *(e.g. Orthoplex Ultra Buffered C Powder)*	**Dose** *(e.g. 2.5g at 4g at 2g at*	**Times Taken** *8am 2pm 7pm*	**With food** *with food, without food with food)*

PERSONAL HISTORY

Do you have children? YES/NO If so, how many?____ Ages of children_____

Number of pregnancies (if applicable)?_____

Are your parents still alive? Father: YES / NO Mother: YES / NO

Please describe your relationship with your Father as a child. Please be as frank as possible.

_____

_____

Did this change? _____ If so, how? _____

_____

Please describe your relationship with your Mother as a child. Please be as frank as possible:

_____

_____

Did this change? _____ If so, how? _____

_____

Was either parent absent for significant periods of time? (months/years)_____

Details: _____

Please show the number of siblings in each group below:

Older brothers _____ Older sisters _____ Younger brothers _____ Younger sisters _____

What sort of relationship did you have with your siblings when young? _____

_____

Has this relationship changed? _____ How? _____

Is there any family history of chronic infections, degenerative disorders, autoimmune disorders, depression, cardiac disease, stroke, diabetes or dementia? YES/ NO

Please include all possible information even if you think it is not relevant:

_____

_____

_____

_____

HAVE YOU EVER:

Been divorced? YES/NO Widowed? YES/NO Re-married? YES/NO

Been retrenched or sacked? YES/NO Details:_____

_____

Lost a child/sibling/friend through illness, accident or miscarriage? YES/NO

Details: _____

Moved house in difficult circumstances? YES/NO When? _____

Details: _____

Moved interstate or to a new country? YES/NO When? _____

Spent time in work which was not suitable for you for any reason? Yes/No

Details: _____

Spent time in the armed forces? YES/NO When?_____

Details:_____

Been in contact with toxic chemicals such as Agent Orange, Carbon tetrachloride, Deildrin or others including gardening chemicals such as Roundup? YES/NO Please give details if possible.

_____

_____

Sought counselling or psychiatric help for any reason? YES/NO

Details: _____

Did this help you? _____

DIGESTIVE

If you experience any of the following, please provide details.

Reactions after eating certain foods? _____

Feel nauseous or bloated after eating any foods? _____

_____

Indigestion? _____

Discomfort or pain? _____

Reflux? _____

Other: _____

FOOD CHOICES

*Please give details of your food consumption on an "average" day, and also be as specific as you can, for e.g. 'cornflakes', or 'rolled oats' **instead of 'cereal'**. Include "additives" like milk (type and quantity), mayonnaise, sauces, sweeteners (sugar, honey, etc); (If there are significant variations, please attach a separate sheet detailing those). Other examples could be 'sandwich' (tell us the type of bread- white, rye, gluten free, etc- the condiments and the fillings), 'salad' (i.e. green salad, pasta salad, white potato salad, etc), eggs (how many, what size, bought or back yard, free range, organic, etc), etc, etc.*
Give details of how food is cooked, including oils used, and type of pan used (e.g. non-stick, aluminium, etc). If you have changed your food choices in the last 12 months, please clearly note this and tell me when you made these changes.

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

Include details of Tea/Coffee *(eg, 2 cups per day; black or white – if white what sort of 'milk' used to make it white, sweetened/unsweetened – if sweetened, what type of sweetener and approx how much. Please further break down 'type of tea', e.g. black, Rooibos, chamomile, etc)*
TEA:

COFFEE:

SOFT DRINKS/CORDIAL *(number of GLASSES daily & type)*:

WATER (*number of LITRES daily – be accurate and specific*):

Is the **WATER** from the tap, bottled or filtered? If filtered, what type of filter?

CRAVINGS:

Please complete only the sections relevant to you in any way.
If you experience any of the following symptoms, please tick and give details where appropriate.

	MILD	MODERATE	SEVERE	
Tremor at rest:	____	____	____	Where is the tremor? _____
Tremor with action:	____	____	____	Where? _____
Muscle rigidity:	_____	____	____	Where? _____

Difficult/slow movements _____ Stooped posture _____

Difficulty in walking _____ Poor balance _____

Tingling or numbness? _____ Where? _____ Clumsiness _____

Fixed facial expression _____ "Freezing" (unable to move) _____

Speech changes _____ Difficulty turning in bed _____

Muscle weakness _____ Fatigue _____

Sleep disturbances _____ Sleepy during the day_____

Dizziness _____

Difficulty doing more than one thing at a time? Details. _____

Pain? _____ If so, where and when? _____

Difficulty with buttons? _____ Laces? ____ or other fine movements? _____

Incontinence/Frequency/Urgency/Urinary frequency at night? _____

Shortness of breath_____ Palpitations _____

Acid reflux/belching _____ Hot flushes/sweating _____

Skin changes _____ Are you confused sometimes? _____

Please list any other symptoms of concern _____

_____

_____

FEMALE

Painful menstruation _____

Irregular menstruation _____

Premenstrual tension _____

Other: _____

Answer the following questions as honestly as possible. Think about how you have been feeling over the past month and how often you have been bothered by any of the following problems. Score the occurrence of each symptom on the following scale: 0 = none, 1 = mild, 2 = moderate, 3 = severe.

SECTION 1: SYMPTOM FREQUENCY

0 None 1 Mild 2 Moderate 3 Severe

1. _____ Unexplained fevers, sweats, chills or flushing.
2. _____ Unexplained weight change; loss or gain.
3. _____ *Fatigue, tiredness.
4. _____ Unexplained hair loss.
5. _____ Swollen glands.
6. _____ Sore throat.
7. _____ Testicular or pelvic pain.
8. _____ Unexplained menstrual irregularity.
9. _____ Unexplained breast milk production; breast pain.
10. _____ Irritable bladder or bladder dysfunction.
11. _____ Sexual dysfunction or loss of libido.
12. _____ Upset stomach.
13. _____ Change in bowel function (constipation or diarrhea).
14. _____ Chest pain or rib soreness.
15. _____ Shortness of breath or cough.
16. _____ Heart palpitations, pulse skips, heart block.
17. _____ History of a heart murmur or valve prolapse.
18. _____ *Joint pain or swelling.
19. _____ Stiff neck or back.
20. _____ Muscle pain or cramps.
21. _____ Twitching face or other muscles.
22. _____ Headaches.
23. _____ Neck cracks or neck stiffness.
24. _____ *Tingling, numbness, burning, or stabbing sensations.
25. _____ Facial paralysis (Bell's palsy).
26. _____ Eyes/vision; double, blurry.
27. _____ Ears/hearing; buzzing, ringing, ear pain.
28. _____ Increased motion sickness, vertigo. _____
29. _____ Light-headedness, poor balance, difficulty walking.
30. _____ Tremors.
31. _____ Confusion, difficulty thinking.
32. _____ Difficulty with concentration or reading.
33. _____ *Forgetfulness, poor short-term memory.
34. _____ Disorientation; getting lost; going to wrong places.
35. _____ Difficulty with speech or writing.
36. _____ Mood swings, irritability, depression.
37. _____ *Disturbed sleep; too much, too little, early awaking.
38. _____ Exaggerated symptoms or worse hangover from alcohol.

SECTION 2: Incidence Questions

Please place a tick below for the incidences applicable to you.

1. ____ You have had a tick bite with no rash or flulike symptoms.
2. ____ You have had a tick bite, an erythema migrans (bullseye rash), or an undefined rash followed by flulike symptoms.
3. ____ You live in what is considered a tick borne infection-endemic area (*almost everywhere in Australia*).
4. ____ You have a family member who has been diagnosed with tick borne infection and/or other tick-borne infections.
5. ____ You experience migratory muscle pain.
6. ____ You experience migratory joint pain.
7. ____ You experience tingling/burning/numbness that migrates and/or comes and goes.
8. ____ You have received a prior diagnosis of chronic fatigue syndrome or fibromyalgia.
9. ____ You have received a prior diagnosis of a specific neuro or autoimmune disorder (lupus, MS, rheumatoid arthritis, PD, MSA, PSP), or of a non-specific autoimmune disorder.
10. ____ You have had a positive Lyme test (IFA, ELISA, Western blot, PCR, and/or Borrelia culture).

Section 3: Overall Health

1. Thinking about your overall physical health, for how many of the past thirty (30) days was your physical health **not** good? _____ days
2. Thinking about your overall mental health, for how many days during the past thirty (30) days was your mental health **not** good? _____ days

For internal office use only:
Section 1: _____
Section 2: _____
Section 3: _____
Section 4: _____

Final: _____

Please attach copies of any CURRENT and/or RELEVANT test results you have had when sending in this health questionnaire. (e.g. MRI reports, blood pressure reading, blood cholesterol results, thyroid function, IGeneX, Infectolab, etc).

Please feel free to provide additional information in the blank space below that may help in planning your return to health.

THIS AGREEMENT MUST BE SIGNED BEFORE AN APPOINTMENT IS MADE.

AGREEMENT FOR HEALING

I understand that becoming well is a journey of persistence and uncertain time, and requires a partnership between me, the patient, and John Coleman, the practitioner.

I also understand that becoming well requires an effective cooperation between myself and my practitioner.

I am aware that, to become fully well, I must be fully dedicated to the advice given by the health practitioners I choose to consult and medicines provided to enhance my progress towards wellness.

I commit myself to the wellness program advised by John Coleman for my individual needs, and will completely dedicate myself to all changes, activities and medicine regimens in order to gain the greatest benefit for my journey towards good health.

Name …….…….. Date …….. Signature …….……..

Thankyou for completing this questionnaire. Once again, I assure you that all information will be held in the strictest confidence. Some details may be used for statistical analysis without any individual answers being revealed. Should RETURN TO STILLNESS need to use individual information for any reason, your permission will be requested before the information is used. Your name and identifying details will never be used outside RETURN TO STILLNESS unless you give express permission.