



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
post only (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 every day? (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:

HEALTH HISTORY

Please list all serious disorders you have had, including childhood and adult 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 surgical procedures and type of anaesthetic:

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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?

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’ (ie 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).

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 _____
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Difficulty in walking _____	Poor balance _____
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Tingling or numbness? _____ Where? _____	Clumsiness _____
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Fixed facial expression _____	“Freezing” (unable to move) _____
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Speech changes _____	Difficulty turning in bed _____
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Muscle weakness _____	Fatigue _____
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Sleep disturbances _____	Sleepy during the day _____
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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 _____
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Acid reflux/belching _____	Hot flushes/sweating _____
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Skin changes _____	Are you confused sometimes? _____
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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.
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 autoimmune disorder (lupus, MS, rheumatoid arthritis), 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

<p>For internal office use only:</p> <p>Section 1: _____</p> <p>Section 2: _____</p> <p>Section 3: _____</p> <p>Section 4: _____</p> <p>Final: _____</p>

Please attach copies of any **CURRENT** and/or **RELAVENT** test results you have had when sending in this health questionnaire. (e.g. MRI, 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 requires a partnership between me, the patient, and John Coleman, the practitioner. To become well, I must be fully dedicated to the advice given and medicines provided without compromise.

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 without compromise.

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.