**ASSESSMENT FOR REFERRAL**

Answering these questions in detail will assist me in giving the best possible advice on the underlying causes of your illness process, and the best practitioner to help you move towards wellness.

My advice is given based solely on the information you provide herein and, therefore, I cannot guarantee accuracy or efficacy of treatment except within these parameters.

Note: To enter data, start typing where it instructs to add or enter text. The space will expand according to your needs.

**Please email this questionnaire once completed to: pdfree@bigpond.com**

**PERSONAL CONTACT DETAILS:**

**Surname/Family Name:** Add text here.

**Given Names:** Add text here

**Address:**  Add text here

**State:**  Add text here **Post/Zip Code** Add text **Country**  Add text here

 **Phone:**  Add text here **Mobile Number** Add text here

**Email:**  Add text here

 **Date of Birth Click or tap to enter a date.**

**Place of Birth (town & country):**  Add text

**Where did you spend your childhood (0-10)?**  Add text here

**Did you live in other towns/areas during your first 20 years?** Yes or No **If so, where?**  Add text here if relevant

**Occupation/Industry (if retired, describe past work):**  Add text here

**DIAGNOSIS / MAIN CONDITION:**

**What is your disease diagnosis (if any)?** Add text here

**When were you first diagnosed?** Add text here

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

Click or tap here to enter text.

**When did these symptoms first become noticeable to you?** Click or tap here to enter text.

## **GENERAL HEALTH:**

**Are you allergic to anything (food, drugs, plants, insect bites, etc.)? Yes/No Please give details:** Click or tap here to enter text.

**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.**

Click or tap here to enter text.

**Do you smoke cigarettes? YES / NO How many per day?** Click or tap here to enter text.

**How long have/had you been smoking?** Click or tap here to enter text.

**When did you stop?** Click or tap here to enter text.

**Do you drink alcohol?** Click or tap here to enter text. **If so, how many drinks per day/week/month?** Click or tap here to enter text.

**How many bowel motions do you have every day? (if this varies, explain):**
Click or tap here to enter text.

**Do you have diarrhoea and/or constipation? If so, which and how often?**Click or tap here to enter text.

**Please give details of any regular exercise you undertake:** Click or tap here to enter text.

**Do you meditate or use any form of relaxation technique?** Click or tap here to enter text.

**Do you sleep well? Describe:** Click or tap here to enter text.

##### HEALTH HISTORY:

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

**Disorder** Click or tap here to enter text. **Age (approx.)** Click to enter text.

**Disorder** Click or tap here to enter text. **Age (approx.)** Click to enter text.

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**Disorder** Click or tap here to enter text. **Age (approx.)** Click to enter text.

**Disorder** Click or tap here to enter text. **Age (approx.)** Click to enter text.

Please list all **surgical procedures** and type of **anaesthetic (general, local, spinal, etc.)**:

#### Surgery: Click or tap here to enter text. When (approx.): Click to enter text. Anaesthetic: Click to enter text.

#### Surgery: Click or tap here to enter text. When (approx.): Click to enter text. Anaesthetic: Click to enter text.

#### Surgery: Click or tap here to enter text. When (approx.): Click to enter text. Anaesthetic: Click to enter text.

#### Surgery: Click or tap here to enter text. When (approx.): Click to enter text. Anaesthetic: Click to enter text.

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

#### Accident: Click or tap here to enter text. When: Click to enter text. Injuries: Click to enter text.

#### Accident: Click or tap here to enter text. When: Click to enter text. Injuries: Click to enter text.

#### Accident: Click or tap here to enter text. When: Click to enter text. Injuries: Click to enter text.

##### MEDICATIONS:

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

***Examples***

**Prescribed Medicine:** *Cogentin, Sinemet* **Dose:** *0.5g*
**Times taken:** *each morning with food* **When commenced:** Feb, 2024

**Prescribed Medicine:** *Normison, Doxycyline* **Dose:** *20mg, 100/25*
**Times taken:** *Twice daily @8am & 6pm*
**When commenced:** Started Oct 2023, Ended Jan 2024.

 **My Medications**

**Prescribed Medicine:** Click or tap here to enter text. **Dose:** Click or tap here to enter text.
**Times taken:** Click here to enter text.
**When commenced:** Click here to enter text.

 **Prescribed Medicine:** Click or tap here to enter text. **Dose:** Click or tap here to enter text.
**Times taken:** Click here to enter text.
**When commenced:** Click here to enter text.

 **Prescribed Medicine:** Click or tap here to enter text. **Dose:** Click or tap here to enter text.
**Times taken:** Click here to enter text.
**When commenced:** Click here to enter text.

 **Prescribed Medicine:** Click or tap here to enter text. **Dose:** Click or tap here to enter text.
**Times taken:** Click here to enter text.
**When commenced:** Click here to enter text.

 **Prescribed Medicine:** Click or tap here to enter text. **Dose:** Click or tap here to enter text.
**Times taken:** Click here to enter text.
**When commenced:** Click here to enter text.

*If you need to add more medications, please and an extra page to the return email.*

**SUPPLEMENTS:**

**What supplements (vitamins, minerals, antioxidants, herbs, homeopathics, etc) are you now taking? Include tablets, capsules, powders, ‘super foods’, ‘health juices’. Include whether you take with or without food, etc. ALL DETAILS ARE REQUIRED INCLUDING BRAND.**

***Examples***

**Brand & Product Name:** *Orthoplex Ultra Buffered C Powder*
**Dose, Time taken & with/without food:** *2.5g at 8am with food, 4g at 2pm without food*

**My Supplements**

**Brand & Product Name:** Click or tap here to enter text.
**Dose, Time taken & with/out food:** Click or tap here to enter text.

**Brand & Product Name:** Click or tap here to enter text.
**Dose, Time taken & with/out food:** Click or tap here to enter text.

**Brand & Product Name:** Click or tap here to enter text.
**Dose, Time taken & with/out food:** Click or tap here to enter text.

**Brand & Product Name:** Click or tap here to enter text.
**Dose, Time taken & with/out food:** Click or tap here to enter text.

**Brand & Product Name:** Click or tap here to enter text.
**Dose, Time taken & with/out food:** Click or tap here to enter text.

**Brand & Product Name:** Click or tap here to enter text.
**Dose, Time taken & with/out food:** Click or tap here to enter text.

**Brand & Product Name:** Click or tap here to enter text.
**Dose, Time taken & with/out food:** Click or tap here to enter text.

 **PERSONAL HISTORY:**

**Do you have children?** Enter text Yes or No **If so, how many?** Click or tap here to enter text. **Ages of children** Click or tap here to enter text.

**Number of pregnancies (if applicable)?** Click or tap here to enter text. **Are your parents still alive?** **Father:** Enter text Yes or No **Mother:** Enter text Yes or No

**Please describe your relationship with your Father as a child. Please be as frank as possible.** Click or tap here to enter text.

**Did this change?** Enter text Yes or No **If so, how?** Click or tap here to enter text.

**Please describe your relationship with your Mother as a child. Please be as frank as possible.** Click or tap here to enter text.

**Did this change?** Enter text Yes or No **If so, how?** Click or tap here to enter text.

**Was either parent absent for significant periods of time (months/years)?**
**Details:** Click or tap here to enter text.

 **Please show the number of siblings in each group below:**

**Older brothers:**Enter number. **Older sisters:** Enter number.
**Younger brothers**: Enter number. **Younger sisters**: Enter number.

**What sort of relationship did you have with your siblings when young?** Click or tap here to enter text.
**Has this relationship changed? If so, how?** Click or tap here to enter text.

**Is there any family history of chronic infections, degenerative disorders, autoimmune disorders, depression, cardiac disease, stroke, diabetes, or dementia?** Enter Yes or No.

**Please include all possible information even if you think it is not relevant:**
Click or tap here to enter text.
 **HAVE YOU EVER**:

 **Been divorced?** Enter Yes or No. **Widowed?** Enter Yes or No. **Re-married?** Enter Yes or No.

 **Been retrenched or sacked?** Enter Yes or No.
**Details:** Click or tap here to enter text.

**Lost a child/sibling/friend through illness, accident, or miscarriage?** Enter Yes or No.
**Details:** Click or tap here to enter text.

**Moved house in difficult circumstances?**  Enter Yes or No. **When?** Enter Year if known. **Details:** Click or tap here to enter text.

**Moved interstate or to a new country?** Enter Yes or No. **When?** Enter Year if known.

**Spent time in work which was not suitable for you for any reason?** Enter Yes or No.
**Details:** Click or tap here to enter text.

 **Spent time in the armed forces?** Enter Yes or No.
**If yes, when?** Click or tap here to enter text.
**Details:** Click or tap here to enter text.

**Knowingly had contact with toxic chemicals such as Agent Orange, Carbon tetrachloride, DDT, Arsenic, Deildrin or others including gardening chemicals such as Roundup/Glyphosate/Paraquat?** Enter Yes or No.

**Please give details if possible**: Click or tap here to enter text.

**Sought counselling or psychiatric help for any reason?** Enter Yes or No.

**Details:** Click or tap here to enter text.

**Did this help you?** Click or tap here to enter text.

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

**Reactions after eating certain foods?** Click or tap here to enter text.

**Feel nauseous or bloated after eating any foods?** Click or tap here to enter text.

**Indigestion?** Click or tap here to enter text.

**Discomfort or pain?** Click or tap here to enter text.

**Reflux?** Click or tap here to enter text.

**Other:** Click or tap here to enter text.

## **FOOD CHOICES**On the following page, please give details of your food consumption on an ‘average’ day, and also be as specific as you can. For example:

* Write specifics like ‘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.
* 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:**Click or tap here to enter text.

**LUNCH:**Click or tap here to enter text.

**DINNER:**Click or tap here to enter text.

**SNACKS:**

Click or tap here to enter text.

**Include details of Tea/Coffee**For example: 2 cups per day: black or white – if white include 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, green, Rooibos, chamomile, etc)

**TEA:** Click or tap here to enter text.

**COFFEE:** Click or tap here to enter text.

**SOFT DRINKS/CORDIAL** (number of GLASSES daily & type): Click or tap here to enter text.

**WATER** (number of LITRES daily – be accurate and specific): Click or tap here to enter text.

**Is the WATER from the tap, bottled or filtered? If filtered, what type of filter?** Click or tap here to enter text.

**CRAVINGS:** Click or tap here to enter text.

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. Enter 0-3 **Unexplained fevers, sweats, chills or flushing.**
2. Enter 0-3 **Unexplained weight change; loss or gain.**
3. Enter 0-3 \***Fatigue, tiredness.**
4. Enter 0-3 **Unexplained hair loss.**
5. Enter 0-3 **Swollen glands.**
6. **­**Enter 0-3 **Sore throat.**
7. Enter 0-3 **Testicular or pelvic pain.**
8. Enter 0-3 **Unexplained menstrual irregularity.**
9. Enter 0-3 **Unexplained breast milk production; breast pain.**
10. Enter 0-3 **Irritable bladder or bladder dysfunction.**
11. Enter 0-3 **Sexual dysfunction or loss of libido.**
12. Enter 0-3 **Upset stomach.**
13. Enter 0-3 **Change in bowel function (constipation or diarrhea).**
14. Enter 0-3 **Chest pain or rib soreness.**
15. Enter 0-3 **Shortness of breath or cough.**
16. Enter 0-3 **Heart palpitations, pulse skips, heart block.**
17. Enter 0-3 **History of a heart murmur or valve prolapse.**
18. Enter 0-3 \***Joint pain or swelling.**
19. Enter 0-3 **Stiff neck or back.**
20. Enter 0-3 **Muscle pain or cramps.**
21. Enter 0-3 **Twitching face or other muscles.**
22. Enter 0-3 **Headaches.**
23. Enter 0-3 **Neck cracks or neck stiffness.**
24. Enter 0-3 **\*Tingling, numbness, burning, or stabbing sensations.**
25. Enter 0-3 **Facial paralysis (Bell’s palsy).**
26. Enter 0-3 **Eyes/vision; double, blurry.**
27. Enter 0-3 **Ears/hearing; buzzing, ringing, ear pain.**
28. Enter 0-3 **Increased motion sickness, vertigo. \_\_\_\_**
29. Enter 0-3 **Light-headedness, poor balance, difficulty walking.**
30. Enter 0-3 **Tremors.**
31. Enter 0-3 **Confusion, difficulty thinking.**
32. Enter 0-3 **Difficulty with concentration or reading.**
33. Enter 0-3 \***Forgetfulness, poor short-term memory.**
34. Enter 0-3 **Disorientation; getting lost; going to wrong places.**
35. Enter 0-3 **Difficulty with speech or writing.**
36. Enter 0-3 **Mood swings, irritability, depression.**
37. Enter 0-3 \***Disturbed sleep; too much, too little, early awaking.**
38. Enter 0-3 **Exaggerated symptoms or worse hangover from alcohol.**

**SECTION 2: Incidence Questions**

 **Please place a** X **below for the incidences applicable to you. Please only ‘enter an X’ if relevant to you. If not, leave it blank.**

1. Enter X **You have had a tick bite with no rash or flu-like symptoms.**
2. Enter X **You have had a tick bite, an erythema migrans (bullseye rash), or an undefined rash followed by flu-like symptoms.**
3. Enter X **You live or have lived in what is considered a tick-borne infection-endemic area (*almost everywhere in Australia, USA, UK, South America, Europe, Africa or Asia*).**
4. Enter X **You have a family member who has been diagnosed with tick borne infection and/or other tick-borne infections.**
5. Enter X **You experience migratory muscle pain.**
6. Enter X **You experience migratory joint pain.**
7. Enter X **You experience tingling/burning/numbness that migrates and/or comes and goes.**
8. Enter X **You have received a prior diagnosis of chronic fatigue syndrome or fibromyalgia.**
9. Enter X **You have received a prior or current diagnosis of a specific neuro or autoimmune disorder (lupus, MS, rheumatoid arthritis, PD, MSA, PSP), or of a non-specific autoimmune disorder.**
10. Enter X **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?** Enter number of days
2. **Thinking about your overall mental health, for how many days during the past thirty (30) days was your mental health not good?** Enter number of days

**For internal office use only:**

Section 1: \_\_\_\_\_\_

Section 2: \_\_\_\_\_\_

Section 3: \_\_\_\_\_\_

Section 4: \_\_\_\_\_\_

**Final: \_\_\_\_\_\_\_**

**IMPORTANT:**Please also attach to return email, any 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 READ AND SIGN AGREEMENT FOR ASSESSMENT:**

* I understand that this questionnaire is only a first step in discerning the underlying causes of my state of ill health.
* I also understand that John Coleman will refer me to a practitioner he believes to be the most suitable to assist my journey to wellness but cannot guarantee successful outcomes.
* 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 understand that John Coleman will forward all relevant information to the practitioner he recommends and agree to this action.

**Full Legal Name** Click or tap here to enter text. **Date:** Click or tap to enter a date. **Consent** [ ] By selecting this checkbox I acknowledge that I consent to the above terms and conditions and acknowledge the information provided is true and correct.

**THANKYOU**
Thank-you 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.