In Natures Hands

Patient Information Form

Confidentiality assured

Date: Referred by:

Name	
Date of Birth	
Address	
Home phone	
Mobile	
Email	
Occupation	
Height	Weight
Next of Kin	Phone

Please list your main concerns or reasons for this appointment

1. _____

2. _____

3. _____

Have you had any investigations/ tests/ operations / hospitalisations. Please list.

_____

_____

_____

_____

Have you experienced major stress in the last 12 months?

_____

_____

_____

_____

Current medications, herbal or nutritional supplements

Name	**Dose**

General Health Questionnaire

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if you have never experienced this symptom.

Gastro-intestinal	Respiratory	Skin	Cardiovascular
☐ Bloating ☐ Flatulence ☐ Reflux/Heartburn ☐ Indigestion ☐ Nausea ☐ Abdominal pain ☐ Constipation ☐ Diarrhea ☐ Food intolerances	☐ Persistent cough ☐ Sneezing, wheezing ☐ Post nasal drip ☐ Ear infections ☐ Itchy eyes, ears, nose, throat ☐ Sore throat	☐ Slow wound healing ☐ Acne ☐ Psoriasis ☐ Dry, flaky skin ☐ Oily skin ☐ Eczema / skin rashes	☐ Excessive fatigue ☐ Shortness of breath ☐ Easy bruising or bleeding ☐ Palpitations ☐ Dizziness ☐ Varicose veins ☐ High blood pressure ☐ High cholesterol
Immune/Lymphatic	**Sleep**	**Emotional**	**Musculoskeletal**
☐ Poor immunity ☐ Recurrent cold / flu ☐ Hayfever / sinusitis ☐ Fluid retention ☐ Cold sores ☐ Inflammed / bleeding gums ☐ Auto-immune disease ☐ Cancer	☐ Insomnia ☐ Difficulty falling asleep ☐ Waking during night ☐ Waking un-refreshed ☐ Regular dreaming ☐ Night sweats	☐ Depression ☐ Anxiety ☐ Mood swings ☐ Poor memory ☐ High stress levels ☐ Feelings of being overwhelmed or unable to cope	☐ Headaches ☐ Migraines ☐ Muscle aches or cramps ☐ Joint pain ☐ Restless legs ☐ Muscle weakness
Endocrine	**Urinary / Renal**	**Male hormone balance**	**Female hormone balance**
☐ Fatigue / poor energy ☐ Recent weight gain ☐ Heat / cold intolerance ☐ Hair falling out ☐ Abdominal weight gain ☐ Thyroid disorder	☐ Excessive urination ☐ Frequent urination ☐ Pain with urination ☐ Incontinence ☐ Bloody, cloudy or smelly urine☐ Urinary tract infection	☐ Low libido ☐ Difficulty starting urine flow ☐ Premature ejaculation ☐ Difficulty maintaining erection ☐ Genital rash or irritation ☐ Painful testicles	☐ Hot flushes ☐ Night sweats ☐ Change in menstrual cycle ☐ Dry hair, skin or vagina ☐ Low libido ☐ Excessive libido ☐ Bleeding after intercourse ☐ Infertility ☐ Miscarriage
Pre-menstrual symptoms (women only)	**Menstrual symptoms (women only)**	**Sexual Health**	**Lifestyle**
☐ Depressed or teary ☐ Anxious or irritable ☐ Feeling aggressive or angry ☐ Breast tenderness ☐ Food cravings ☐ Fluid retention/bloating ☐ Back pain ☐ Abdominal pain ☐ Headaches or migraines	☐ Long intervals between cycles ☐ Cycles longer than 32 days ☐ Cycles shorter than 24 days ☐ Heavy blood flow or flooding ☐ Passing of blood clots ☐ Very light blood flow ☐ Spotting before or after bleed ☐ Period pain	☐ Thrush ☐ Genital herpes ☐ Sexually transmitted disease ☐ Irregular pap smear ☐ Painful intercourse ☐ Burning or itching pain on genitals	☐ Smoker _____ / day ☐ Passive smoker ☐ Coffee _____/ day ☐ Tea _____/ day ☐ Alcohol _____ /week ☐ Recreational drugs ☐ Exercise ___ / week ☐ Excessive plane travel ☐ Radiation exposure ☐ Pesticide / herbicide exposure ☐ Bleach and ammonia use (cleaning) ☐ High stress levels

Please turn over for last page

Medical History – Self and family - please circle or tick

	Self	Mother's side	Father's side
Allergies			
Arthritis			
Asthma			
Autoimmune disease			
Bowel disorder			
Cancer			
Cardiovascular disease			
Depression			
Diabetes			
Eczema or Psoriasis			
Epilepsy			
Endometriosis			
Fibroids			
Gastroenteritis/Giardia etc			
Hepatitis			
Hospitalisations/operations			
Hysterectomy			
Osteoporosis			
Sexually transmitted disease			
Thyroid disease			
Other			