HEALTH HEALING *life*
CLINIC

Address: 18 Jeffcott St Wavell Heights
Phone: 07 3260 5946
Email: contact@healthhealinglife.com

Name: Age: DOB: Today's Date:

Address: Email:

Home Phone: Mobile: Occupation:

Relationship Status: Names and ages of Children:

How did you hear about us:

Names of any current practitioners:

Emergency contact details

Name: Phone: Relationship to you:

Doctor/GP contact details:

Current Medications:

Main reason for visit:

Health History

Childhood Health (please include major illness, medication and surgery):

Adult Health (please include major illness, medication and surgery):

Family Medical Health History:

Daily Rhythms

When do you have the most energy?

When are you most tired?

Usual sleep time: Usual wake time:

What is your quality of sleep?

Lifestyle Health

Do you suffer from any emotional conditions?

Please describe how this affects you?

Is there anything at work that stresses, drains, hurts or frustrates you?

Is there anything at home that stresses, drains, hurts or frustrates you?

Is there anything that stresses, drains, hurts or frustrates you in your social life?

Nutritional overview *Please tick any of the following symptoms or conditions that you currently experience*

EARS
- [ ] Itchy Ears,
- [ ] Hearing loss or Blocked ears
- [ ] Ringing or buzzing in ears
- [ ] Earache or Ear Infections

EYES
- [ ] Watery or itchy eyes
- [ ] Swollen, reddened or sticky eyelids
- [ ] Bags or dark circles under eyes
- [ ] Blurred/tunnel vision or visual disturbance

NOSE
- [ ] Stuffy nose or Nasal discharge
- [ ] Sinus congestion or Sinus infection
- [ ] Hay fever or Sneezing attacks
- [ ] Postnasal drip or Excessive mucus

MOUTH/ THROAT
- [ ] Chronic coughing or clearing of throat
- [ ] Frequent gagging or difficulty swallowing
- [ ] Sore throat, hoarseness, loss of voice
- [ ] Swollen or discoloured tongue, gums, lips
- [ ] Mouth ulcers or Sore gums
- [ ] Bleeding gums, sensitive teeth
- [ ] Cracks in the corner of your mouth

DIGESTIVE TRACT
- [ ] Episodic nausea or vomiting
- [ ] Diarrhoea - Episodic or recurrent
- [ ] Constipation – episodic or recurrent
- [ ] Abdominal Bloating – episodic or recurrent
- [ ] Flatulence – burping, or passing gas
- [ ] Heartburn – episodic or recurrent

APPETITE EATING BEHAVIOUR
- [ ] Loss of appetite
- [ ] Food Cravings
- [ ] Binge eating / drinking or Compulsive eating
- [ ] Excessive weight or weight gain
- [ ] Eating when sad or down
- [ ] Overeating or eating when not hungry
- [ ] Feeling guilty about food

EMOTIONS / FEELINGS
- [ ] Mood swings
- [ ] Anxiety, fear or nervousness
- [ ] Anger, irritability, or aggressiveness
- [ ] Given up, at a loss
- [ ] teary, sad
- [ ] depleted, low, depressed
- [ ] high, excitable, on a rush

MIND / COGNITION
- [ ] Poor memory
- [ ] Confusion, poor comprehension
- [ ] Poor concentration
- [ ] Poor physical coordination
- [ ] Difficulty in making decisions
- [ ] Stuttering or Stammering or Slurred speech
- [ ] Learning disabilities

LUNGS
- [ ] Chest congestion or Productive chest cough
- [ ] Asthma – wheezing or coughing spasms
- [ ] Shortness of breath or Difficulty breathing
- [ ] Recurrent or chronic bronchitis

HEART
- [ ] Irregular or skipped heartbeat
- [ ] Rapid or pounding heartbeat
- [ ] Chest pain

HEAD
- [ ] Headaches / Migraines
- [ ] Faintness or light-headedness
- [ ] Dizziness or vertigo
- [ ] Insomnia or sleep disturbance

SKIN
- [ ] Acne
- [ ] Hives, rashes, or dry skin, flaky scalp
- [ ] Bumps or rough skin on the outer thighs or arms
- [ ] Flushing or hot flushes
- [ ] Eczema

NAILS/ HAIR
- [ ] Hair Loss
- [ ] Hair splits or breaks easily
- [ ] Dandruff
- [ ] Brittle nails
- [ ] White marks on nails
- [ ] Cracks on the sides of finger tips
- [ ] Vertical ridges on nails

JOINTS/ MUSCLES
- [ ] Pain or aches in the joints or arthritis
- [ ] Pain or aches in muscles
- [ ] Stiffness or limitation of movement
- [ ] Feeling of weakness or tiredness
- [ ] muscle twitches or tremors

ENERGY/ ACTIVITY
- [ ] Fatigue, sluggishness or lethargy
- [ ] Apathy or Loss of motivation
- [ ] Hyperactivity or Restlessness

CHEMICAL PROFILE
- [ ] Sensitive/ reaction to perfumes, smoke, pollutants
- [ ] Regular or excessive contact with organic chemicals (i.e. Insecticides, herbicides, petrochemicals etc)
- [ ] Exposure to lead, mercury, copper or cadmium
- [ ] Are you sensitive to food additives or preservatives
- [ ] Excessive or long term antibiotic treatment
- [ ] Have you ever smoked / excessive passive smoking
- [ ] Alcohol or drug intake (Past,present,regular, excessive)
- [ ] Do you react to caffeine-containing foods or drink
- [ ] Do you have mercury fillings in your teeth

OTHER
- [ ] Recent illness or Recurrence of illness
- [ ] Fluid or Water retention
- [ ] Frequent or urgent urination
- [ ] General itch or discharge

Food and Digestion

Do you have any known or suspected food allergies or sensitivities?

Please share your normal daily food intake - some people like to keep an actual food diary for a couple of days, you can also bring this along.

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

Please specify the amount of consumption for the following

Alcohol:	Coffee:
Cigarettes:	Drug use:

Do you experience any of the following:

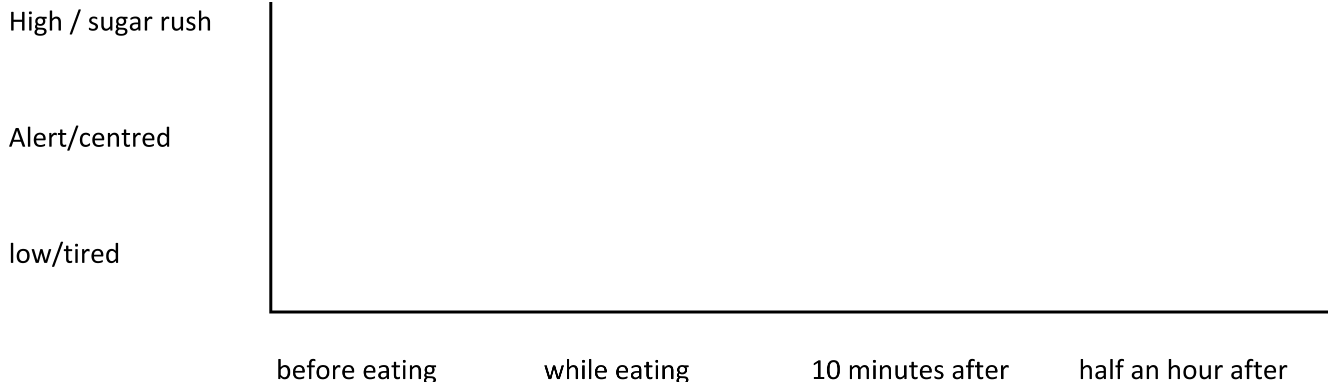
Indigestion	☐	Bloating	☐
Reflux	☐	Flatulence	☐
Nausea	☐	Diarrhoea	☐
Burping	☐	Constipation	☐
Stomach pain	☐	Lower Abdominal pain	☐
Vomiting	☐	Bleeding from the bowel	☐

Do you experience food cravings? Please describe particular foods or sweet, salty, fatty, carbohydrate, other

Are there any foods you dislike or cannot eat?

Do you experience any food related emotional conditions?

Please draw on the graph how eating affects your energy levels



Do you experience any of the following before, during or after eating:

Experience	**Before**	**During**	**After**
Lightheaded, faint or dizzy	☐	☐	☐
trembling or shaking hands	☐	☐	☐
Irritability	☐	☐	☐

Men's Health

Do you have any concerns about your prostate health?	Yes ☐	No ☐
Do you have any concerns about your sexual libido?	Yes ☐	No ☐
Are you concerned with any genital lumps, bumps, rashes, itchiness or discharge?	Yes ☐	No ☐
Do you regularly talk to someone about your health? i.e. friend, partner, G.P, son / daughter.	Yes ☐	No ☐

Please rank the following questions on a scale of 0-10 (10 being the highest)

	0	2	4	6	8	10
How healthy are you now?						
How healthy have you been throughout your life?						
How healthy has/had your father been throughout his life?						

Do you have any infertility concerns? Yes ☐ No ☐

If yes please tick any of the following that relate to your infertility concerns

Unexplained infertility	☐	Sperm antibodies	☐
Sperm motility	☐	Vasectomy/ reversal	☐
Sperm count	☐	Recurrent miscarriage	☐
Sperm morbidity	☐	Chromosomal abnormalities	☐

Do you have any concerns with your weight or changes in your body shape?

Please share any other information that might be relevant to your health or wellbeing

Thank you