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/	Chronic coughing or clearing of throat	☐
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	Episodic nausea or vomiting	☐
TRACT	Diarrhoea - Episodic or recurrent	☐
	Constipation – episodic or recurrent	☐
	Abdominal Bloating – episodic or recurrent	☐
	Flatulence – burping, or passing gas	☐
	Heartburn – episodic or recurrent	☐
APPETITE	Loss of appetite	☐
EATING	Food Cravings	☐
BEHAVIOUR	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 /	Mood swings	☐
FEELINGS	Anxiety, fear or nervousness	☐
	Anger, irritability, or aggressiveness	☐
	Given up, at a loss	☐
	teary, sad	☐
	depleted, low, depressed	☐
	high, excitable, on a rush	☐
MIND /	Poor memory	☐
COGNITION	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 Loss	☐
HAIR	Hair splits or breaks easily	☐
	Dandruff	☐
	Brittle nails	☐
	White marks on nails	☐
	Cracks on the sides of finger tips	☐
	Vertical ridges on nails	☐
JOINTS/	Pain or aches in the joints or arthritis	☐
MUSCLES	Pain or aches in muscles	☐
	Stiffness or limitation of movement	☐
	Feeling of weakness or tiredness	☐
	muscle twitches or tremors	☐
ENERGY/	Fatigue, sluggishness or lethargy	☐
ACTIVITY	Apathy or Loss of motivation	☐
	Hyperactivity or Restlessness	☐
CHEMICAL	Sensitive/ reaction to perfumes, smoke, pollutants	☐
PROFILE	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:

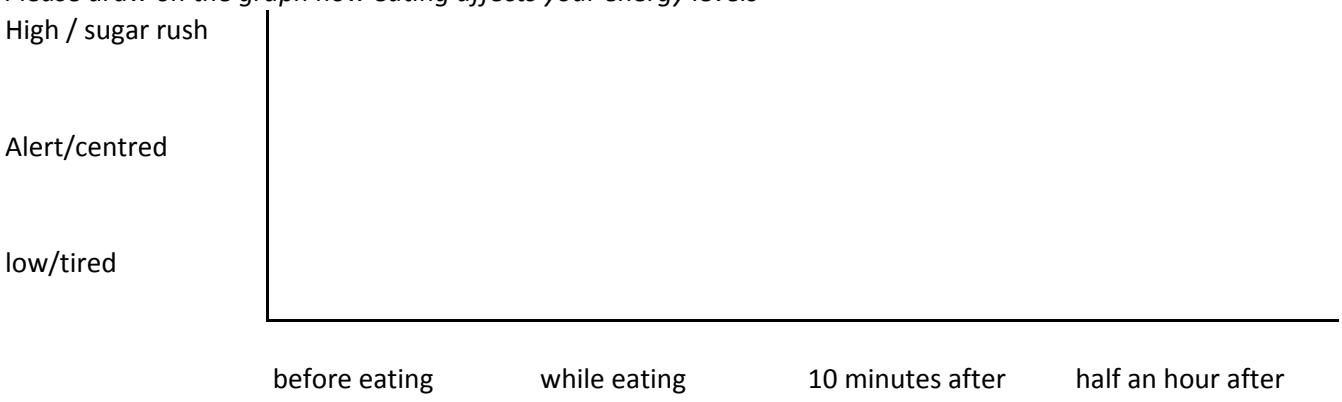
Indigestion	☐	Bloating	☐
Reflux	☐	Flatulence	☐
Nausea	☐	Diarrhoea	☐
Burping	☐	Constipation	☐
Stomach pain	☐	Lower Abdominal pain	☐
Vomiting	☐	Bleeding from the bowel	☐

Do you experience food cravings? Please describe particular foods or tastes eg. 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	☐	☐	☐

Women's Health and Healing

Please list any women's health medications or hormonal contraceptives:

When was your last PAP Smear? Breast check? Bone density study?

Are you currently pregnant? Are you planning a pregnancy?

Breast health

Do you have any lumps or bumps?

Do you have any sensitive areas?

Do you have any concerns with your breasts?

How do you feel about your breasts?

Menstrual Cycle

Age at first period: How often do you get your period?

What day are you in your current cycle (Day 1 being the first day of bleeding)?

What day in your cycle do you normally ovulate? Is your cycle regular?

Describe how you feel before your period:

Describe your period:

Describe any other symptoms or concerns you have with your menstrual cycle:

Describe any thoughts, feelings or experiences you have around ovulation:

Describe any concerns or health problems that you feel are related to a hormonal issues:

Menopause /Peri-menopause

At what age did you transition to no periods? Are you still transitioning?

Describe your experience of transitioning to menopause:

Have you experienced any of the following during your transition to menopause

Experience	**Past**	**Present**	**Comments**
Hot flushes	☐	☐	
Night sweats	☐	☐	
Weight gain, change in body shape	☐	☐	
Headaches, body aches or stiffness	☐	☐	
Rapid heart beat	☐	☐	
Urinary and bladder changes	☐	☐	
Vaginal dryness/itching	☐	☐	
Libido Changes	☐	☐	
Emotional changes	☐	☐	
Palpitations, anxiety	☐	☐	

Do you have any other health concerns related to menopause?