# CLIENT HEALTH SCREEN FORM (Confidential)

Please complete this form accurately and honestly, then return it via email at least 24 hours prior your appointment.

(Allow 20 minutes to complete)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME: |  |  | WORK PHONE: |  |
| ADDRESS: |  |  | HOME PHONE: |  |
|  |  |  | MOBILE: |  |
|  |  |  | E-MAIL: |  |
|  |
|  |  |  |  |  |
|  |  |  |  BLOOD GROUP: |  |
| DOB/AGE: |  |  | HEIGHT: |  |
| SEX: |  |  | WEIGHT: |  |
| ETHNICITY: |  |  | BLOOD PRESSURE: |  |
| OCCUPATION: |  |  |
| NUMBER OF CHILDREN (+AGES): |  |  |

**Who can I thank for referring you to my clinic?**

**What are your main concerns regarding your health?**

**Section 1: Medical History & Past Treatments**

An accurate timeline of your medical history is important. Please include all diagnoses, traumas, highly stressful periods, hospitalisations, surgeries and other major treatments. Attach additional pages if necessary.

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| --- |
| **0-5 years:** |
| **5-10 years:** |
| **10-20 years:** |
| **20-30 years:** |
| **30-40 years:** |
| **40-50 years:** |
| **50-60 years:** |
| **60-70+ years:** |

**Section 2: Family History**

Please list/describe all known diseases of the following family members, including physical and mental illnesses, drug/alcohol addictions, and allergies.

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| --- |
| Mother: |
| Father: |
| Immediate Family Members (brothers, sisters, grandparents, aunts, uncles): |

**Section 3: Current Symptoms**

Please list your current symptoms in order of severity. Symptoms include, for example, fatigue, muscle pain, joint pain, nausea, dizziness, headaches, sleep disturbance (insomnia, etc.), excessive thirst/hunger, excessive sweating, pale skin, feelings of excessive heat/cold, digestive issues (e.g. constipation, diarrhea). Attach additional pages if necessary.

|  |  |
| --- | --- |
| **Symptom** | **Date first experienced**  |
|  |  |
|  |  |
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|  |  |
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|  |  |
|  |  |

**Section 4: Current Health Status and Lifestyle**

|  |  |
| --- | --- |
| If female, are you pregnant? | ☐ Yes ☐ No ☐ N/A |
| If female, are you attempting to conceive? | ☐ Yes ☐ No |
| How would you rate your energy level, on average? (circle one) |  0 1 2 3 4 5 6 7 8 9 10No energy High energy |
| How would you rate your sleep quality? (circle one) |  0 1 2 3 4 5 6 7 8 9 10Very Poor Excellent |
| How many hours per night do you sleep, on average?  |  |
| Does stress affect you? If yes, what stresses you and how does it impact your life? |  |
| Do you suffer recurrent colds/flu or infections? If yes, how often does this occur and how long has this be happening for? |  |
| Do you have regular daily bowl movements? If so, how many on average and what is the consistency? (circle appropriate one)What time of day do you have your bowl movement? | ☐ Yes ☐ No0 1 2 3 4 5 6 7 8 9 10loose - soft – formed - hard - undigested food particles visible |
| How many liters of water do you drink per day, on average?  |  |
| Do you have filtered water at home? | ☐ Yes ☐ No |
| Do you drink alcohol? If so, how many standard drinks per day or per week do you drink on average?  | ☐ Yes ☐ No\_\_\_\_\_\_\_\_\_ standard drinks per day\_\_\_\_\_\_\_\_\_ standard drinks per week |
| Do you smoke cigarettes? If so, how many cigarettes do you smoke per day on average? | ☐ Yes ☐ No\_\_\_\_\_\_\_\_\_ cigarettes per day |
| Do you drink coffee on a daily basis? If so, how many cups per day? | ☐ Yes ☐ No\_\_\_\_\_\_\_ cups per day |
| Are you currently engaged in any form of exercise? If yes, please describe.  | ☐ Yes ☐ NoDescribe:  |
| Are you on prescription medication? | ☐ Yes ☐ NoDescribe: |
| Have you taken antibiotics in the last 12 months? | ☐ Yes ☐ No |
| Do you take any supplements or herbal remedies? | ☐ Yes ☐ NoDescribe: |
| Have you been hospitalized OR had anesthesia recently? | ☐ Yes ☐ No |
| Do you use any form of hormonal contraception? | ☐ Yes ☐ No |
| Are you vaccinated for SARS-CoV-2 (COVID 19) | ☐ Yes ☐ No |
| Are you a blood donor? | ☐ Yes ☐ No |
| Are you a vegetarian? | ☐ Yes ☐ No |
| Are you vegan | ☐ Yes ☐ No |
| Do you want to improve your health status? If yes, please describe some of the goals you have for yourself and your motivation. | ☐ Yes ☐ NoGoals:Motivators: |

**Section 5: Dietary Schedule & Food Habits**

Please provide an example of your dietary schedule for one typical weekday (e.g. Monday-Thursday) and one typical weekend day (e.g. Saturday/Sunday). List all meals, snacks and beverages (coffee, alcohol, soft drinks, juices etc.) for the entire day and indicate which meals/snacks were prepared at home with an ‘H’ and those purchased as packaged food, restaurant/cafe food and take-away food as ‘O’ (for ‘out’)

|  |  |  |
| --- | --- | --- |
| **Time** | **Typical Weekday** | **Typical Weekend Day** |
| 5:00-7:00am |  |  |
| 7:00-9:00am |  |  |
| 9:00-11:00am |  |  |
| 11:00am-1:00pm |  |  |
| 1:00-3:00pm |  |  |
| 3:00-5:00pm |  |  |
| 5:00-7:00pm |  |  |
| 7:00-9:00pm |  |  |
| 9:00-11:00pm |  |  |
| 11:00pm-1:00am |  |  |
| 1:00am-3:00am |  |  |

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| --- |
| What is your favorite food? |
| What are your five most consumed foods?1.
2.
3.
4.
 |
| Was your conception planned by your parents? ☐ Yes ☐ NoIf there were any stressors during the pregnancy of your mum with you, please list:Were you born naturally? ☐ Yes ☐ NoIf medical interventions where used, please list which? |
| Have you been breastfed or bottle-fed as a child? ☐ Yes ☐ NoIf so, for how long? |
| What where the staple foods that you consumed when you were a child? |
| Are there particular emotions that occur around food for you? | ☐ Yes ☐ NoDescribe: |
| Do you still follow any ingrained habitual food habits from your childhood? | ☐ Yes ☐ NoDescribe: |
| Would you consider yourself a fast eater? | ☐ Yes ☐ No |
| Do you engage in other activities while eating? | ☐ Yes ☐ No |

**Acknowledgement and Consent**

* I acknowledge that the above information, to the best of my knowledge, is correct.
* I understand that my personal information will be kept in a secure place and will not be released to anyone without my written permission.

Signed Date

Confidentiality Policy: All personal information provided is strictly confidential and will not be subject to misuse, loss, unauthorised access, modification or disclosure. Personal information will not be shared, sold or given to any third parties without consent, and will only be used or disclosed for its original purpose

Thank you for detailing this important information about your medical and health history.

Please send this form back to **officedoctorverena@gmail.com** at least 24 hours prior to your consultation