# CLIENT HEALTH SCREEN FORM

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

(Allow approximately 15 minutes to complete).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME OF PARENT(S)/GUARDIAN: |  |  | NAME OF CHILD: |  |
| ADDRESS: |  |  | HOME PHONE: |  |
|  |  |  | MOBILE: |  |
|  |  |  | E-MAIL: |  |
|  |  |  |
|  |  |  |  BLOOD GROUP: |  |
| DOB/AGE: |  |  | HEIGHT: |  |
| SEX: |  |  | WEIGHT: |  |
| ETHNICITY: |  |  |

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

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

**Section 1: Medical History**

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

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| --- |
| **0-5 years:**  |
| **5-10 years:**  |
| **10-20 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:** |

**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**  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

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

|  |  |
| --- | --- |
| 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 have 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 bowel 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 |
| 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 have an annual flu vaccination? | ☐ Yes ☐ No |
| Are you vaccinated for SARS-CoV-2 (COVID 19)? | ☐ 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. | Goals:Motivation: |

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| **Are there any other factors that you feel are appropriate to inform Doctor Verena of that may affect your healing?** |
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**Section 5: Dietary Schedule & Food Habits**

Please provide an example of your dietary schedule for one typical week day (e.g. Monday-Thursday) and one typical weekend day (e.g. Saturday/Sunday). List all meals, snacks and beverages (soft drinks, juices, coffee, alcohol, 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 |  |  |

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| --- |
| What is your favorite food? |
| What are your five most consumed foods?1.
2.
3.
4.
5.
 |
| Was your conception planned? ☐ Yes ☐ No |
| Where there any stressful events during your mum’s pregnancy with you? |
| 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? |
| Are there particular emotions that occur around food for you? | ☐ Yes ☐ NoDescribe: |
| Would you consider yourself a fast eater? | ☐ Yes ☐ No |
| Do you engage in other activities while eating? | ☐ Yes ☐ No |

I recognise that by providing my practitioner with complete details of my health history, I am enabling her to regard all aspects of my previous and current health status in my treatment. By not disclosing vital information this may have an impact on the success of my treatment outcomes. I have answered all questions to best of my ability and I understand the statement above. All case details are confidential and will be treated as such.

**Parent/ Guardian**

|  |  |  |  |
| --- | --- | --- | --- |
| **signature**: |  | **Date**: |  |
|  |  |  |  |

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

*Doctor Verena looks forward to working with you.*