**STRICTLY PRIVATE & CONFIDENTIAL**

**Pre-Consultation Homeopathic Health History Record ADULT FEMALE**

**Please complete as much as you can & use additional sheets of paper if you require more space.**

**If you have any questions about the questionnaire, please telephone me on 07 3368 1300**

**Name :**

**Date of birth:**

**Marital status:**

**Names & ages of any siblings:**

**Names & ages of any children:**

**Address:**

**E-mail address:**

**Please indicate that you are happy to receive e-mail confirmation & information from us Yes / No**

**Telephone number: Home Work**

**Mobile:**

**For distance consultations, please indicate preferred method of contact (We recommend Skype) Please circle -**

**E-Mail Telephone : Home – Work – Mobile -................................**

**Skype – User Name................................................................................................................................**

**Occupation:**

**Name of GP & surgery registered at:**

**Dates & names of any Vaccinations received:**

**Any observations post vaccination: i.e. fever, fitting, excessive bruising/ swelling around site of vaccination etc.**

**How did you hear about Bardon Natural Health Centre?**

**Childhood Diseases: Please tick which you have had & indicate age/ dates if known / add disease if not indicated:**

**Chickenpox**

**Mumps**

**Measles**

**Rubella**

**Whooping cough**

**Hospitalisations: - Dates & condition if applicable**

**Operations – Dates & type if applicable**

**Medical Diagnostic tests/ consultation dates & diagnosis, if applicable:**

**Blood Tests:**

**X-Ray:**

**CT Scan**

**Ultrasound**

**Hearing Test**

**Other:**

**Medical Prognosis – If known.**

**Presenting Complaints:**

1. **What are you main, current concerns about your health?**

**In each condition please indicate: -**

**i) How long you have had the condition**

**ii) Any medical diagnosis & consultant diagnosis**

**iii) When & how it started**

**iv) Any treatments (medical or natural) you have received so far & their effectiveness**

**v) Anything which makes the condition worse or better**

**vi) How this affects you & everyday living**

**a)**

**b)**

**c)**

**d)**

**e)**

**f)**

1. **What’s your experience of Homeopathy to date?**
2. **What would like Homeopathy to do most for you?**

**4) Please comment on your general:**

1. **Health – How would you describe your current overall well-being?**
2. **Sleep, Duration, patterns etc**
3. **Symptoms whilst sleeping –**

**Restlessness or restless limbs**

**Sleep walking,**

**Frequent waking times,**

**Disturbing unusual or repetitive dreams – Describe**

1. **Temperament -**

**How would you describe your general mood/temperament?**

**Have you any fears or phobias?**

**What about yourself/personality would you change if anything?**

1. **Energy – Include any noticeable times of day/ night when most/least energetic**

**Please rank your current energy on a scale of 1 – 10, 10 being most energetic**

1. **Appetite, food preferences –**

* **What foods do you enjoy or crave?**
* **What foods do you particularly dislike?**
* **Which foods have you sensitivity to?**

1. **Digestion – Which of the following have do you/ have you experience of either currently or in the past.**

**Pain**

**Bloating**

**Indigestion**

**Diarrhoea**

**Constipation**

**Wind – Downward & or upward (i.e. Belching)**

**6) Menstrual Pattern**

**What age did you start?**

**What is the flow & duration like?**

**What about PMT?**

**6) Sexual health**

**a) Please indicate if any of below have been significant in your history & give details where appropriate:**

**Candida/Thrush -**

**Genital Herpes -**

**Other infections -**

**Unusual pain/inflammation/discharges –**

**Pain on urination/discoloured or unusual smelling urine**

**b) Any concerns with sexual intercourse**

**Any difficulty reaching orgasm - Yes/ No**

**6) Pregnancy & Conception** (If relevant otherwise please ignore)

**How easily have you been able to conceive?**

**How was the pregnancy/ pregnancies?**

**What was the birth process like for you?**

**How well were you able to breast feed?**

**How was becoming a mother?**

**7) Allergies:**

**Have you any allergies to :**

1. **Drugs,**
2. **Food,**
3. **Environment? i.e. pollens, petrochemicals, perfumes, moulds, pesticides etc**
4. **Sinus/Hay-fever?**

**If yes, what, when diagnosed or noticed**

**What specifically are you allergic to – please list all known allergens**

**How does this affect you?**

**8) Current Medication/s**

**Please list any current medication you are taking, amount & what for:**

**Do you use or have you used recreational drugs?**

**If yes – What, when & how frequently**

**9) Family Health History:**

**Maternal**

**Mother’s health :**(if alive) If deceased cause of death

**If know please state the health of your mother during her pregnancy with you & any other major life events which took place at that time.**

**If known – Were you breast-fed?**

**Grandmother’s heath :**(if alive) If deceased cause of death

**Grandfather’s Health:**(if alive) If deceased cause of death

**Paternal:**

**Father’s Health** (if alive) If deceased cause of death

**Grandmother’s health :**(if alive) If deceased cause of death

**Grandfather’s Health:**(if alive) If deceased cause of death

**10) a) Please list any major life experiences /significant events which you feel may have contributed to your health**

**b) Any other information you feel that would be useful for me to know**

In accordance with the privacy Act, your personal information will not be disclosed to any other person.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Full Name in Capitals) give my permission for Jane Lindsay to record my health history and associated details and provide a homeopathic preparation accordingly. I acknowledge that Homeopaths are not qualified to diagnose illness or disease and that Homeopathy does not take the place of medical treatment. If you are in doubt, please consult your GP.

Always seek medical advice in an emergency

PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important information**

***If you have been diagnosed with or suspect you may have a pre-existing medical condition you should consult your GP for advice, diagnosis and treatment and always inform your health professional before starting any alternative or additional therapies, treatments or making any major changes in your diet or exercise programme.***

**Please complete as much as you can & either bring with to consultation on the day or e-mail me on** [**Jane@janelindsay.com.au**](mailto:Jane@janelindsay.com.au)

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