ENVISION HEALTH
PROVIDING ALTERNATIVE HEALTH SOLUTIONS

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Female Patient Card

Date_____

NAME:_____

ADDRESS:_____

SUBURB:_____POSTCODE:_____

PHONE:_____ BUS. No:_____MOBILE:_____

EMAIL:_____

DATE OF BIRTH_____/_____/_____Current age_____PLACE OF BIRTH_____

MARITAL STATUS_____CHILDREN_____

OCCUPATION_____ HEALTH FUND_____

REFERRED BY _____ DOCTOR_____

BLOOD GROUP _____ALLERGIES_____

Where did you hear about this clinic?_____

Have you ever had previous Naturopathic care?_____If yes state when_____

And what for: _____

Was this successfully resolved? _____

MAJOR COMPLAINTS

_____

_____

_____

_____

_____

OTHER COMPLAINTS

CURRENT MEDICATION & WHY PRESCRIBED

NATURAL SUPPLEMENTS

List Surgical Operation and approximate date

Major Accidents

List any contagious diseases you may have come in contact with

Do you or any known family members suffer from any of the following (list relationship of family members)

Cancer	☐	Epilepsy	☐
Diabetes	☐	Heart Disease	☐
Chronic Fatigue	☐	Fibromyalgia	☐
Thyroid Under/Overactive	☐	Other	☐

Diet

Do you crave any sort of food?_____

List what foods you eat/ examples of foods or dishes, drinks and if you skip meals

Before Breakfast _____

Breakfast

_____

_____

Morning Tea

_____

Lunch

_____

_____

Afternoon Tea

_____

Dinner

_____

_____

Supper_____

Are there any foods that you **avoid**: or **have reactions to**:

_____

_____

_____

_____

_____

Life style factors

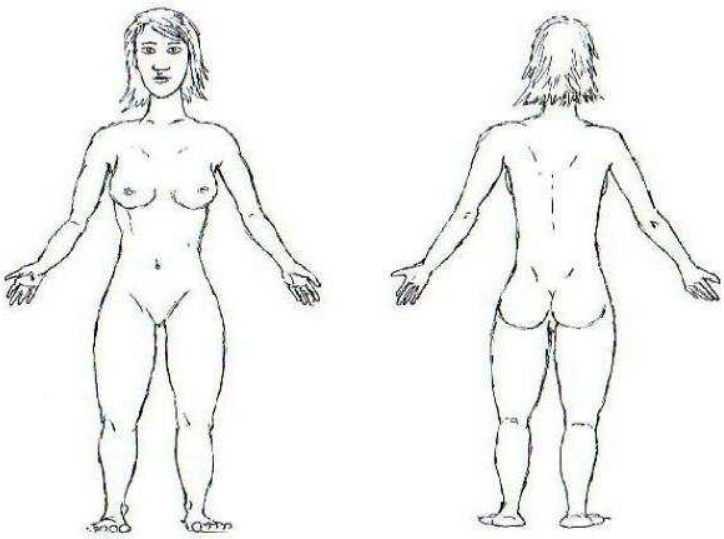
Do you Exercise? If so what type and how long_____

_____

How long do you think natural therapy will take to begin to have the desired effect?_____

What are you willing to do in order to achieve these results?_____

Are you aware of any obstacles in achieving you desired outcome?_____



Highlight any areas of concern

_____
_____
_____
_____
_____
_____

Do you consume the following and how much per day?

Coffee _____Tea_____

Soft drink _____Sweets/Lollies_____

Cordial_____Fruit Juice_____

Do you add sugar to food/beverages?_____

How many teaspoons per day?_____

Cigarettes_____strength_____

Alcohol _____type_____

How oftern_____

Do you take recreational drugs?_____

Type_____Frequency_____

How much water do you drink a day_____

Is the water filtered/ bottled_____

Sleep: No problems; average hours of sleep you get_____ ___Problems falling asleep, Sleep apnea

waking up/ how often _____ what time _____ Waking tired _____

What time do you go to sleep_____ What time do you wake up_____

Bowels: frequency _____ consistency: soft formed, pebbly, hard dry, mushy, runny,

urgency, explosive diarrhea, Other.

Do you suffer from any of the following gastrointestinal issues:

- Nausea after eating_____ Burping/ Belching_____ Gas/Flatulence_____
- Bloating_____ Heart burn_____ Offensive Gas/Flatulence_____
- Pains in the stomach_____ Pain on elimination_____ Frequent vomiting_____

Other:

_____

Female Health:

Periods: Oral contraceptive pill, Mirena, Implant, Other _____ Length of time on this _____

Regular, Irregular, length of cycle in days ____ , how many days do you bleed _____

The menstrual flow is: light, medium, heavy, clots, dark red, bright red, brown tinged, Other _____

Any Pain associated with periods:_____

Tampons, Pads, what size used on heavy bleed days _____

What are the main reasons you have sought naturopathic care: (Select as many as you wish)

□Weight loss_____ □Disease Prevention____ □Pre-conception care_____ □Cardiovascular health_____
□Diet_____ □Energy_____□Immune system_____□Sports enhancement_____

Other:

Informed consent for naturopathic care

I declare that the above information is true and correct and indemnify Leigh-Anne M Simms and or Juan Jose Polit Of Envision Health Qld of any liability for any false or misleading statements given.

I understand and accept that the naturopathic treatment received by your office is of a holistic therapeutic nature and does not attempt to diagnose or treat disease. I also understand and accept that the Cellular Health Analysis (VIA), Live blood analysis, Iridology, Kinesiology/muscle testing, Vega or any other tests performed by the clinic are not diagnostic in any way.

I understand and accept that data collected about myself during this consultation and subsequent consultations will remain the property of Envision Health Qld, as part of case history records. This information will remain private and confidential at all times.

I understand the above information and accept Naturopathic treatment at Envision Health Qld

Name_____Signature_____Date_____

Practitioner only

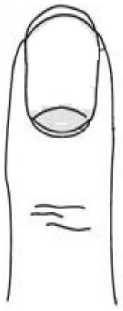
Energy _____BP _____PO2_____ PPM _____ PH Saliva _____Zinc_____

VLA: Height _____Weight_____Waist_____ Wrist _____

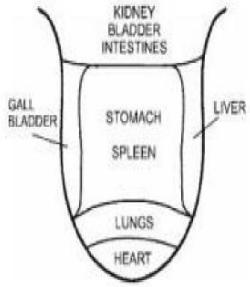
Activity _____ RES:_____ Reac: _____

Nails:

- ☐ Dry/brittle
- ☐ Flaking /peeling
- ☐ Split
- ☐ Zinc
- ☐ Calcium
- ☐ Vertical
- ☐ Horizontal
- ☐ Spoon
- ☐ Clubbing
- ☐ Moons
- ☐ Beau's



Tongue:



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Iris Constitution:_____

Priorities:_____

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General: _____

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