ENVISION HEALTH

PROVIDING ALTERNATIVE HEALTH SOLUTIONS

# 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 _____

DATE OF LAST PHYSICAL EXAMINATION & BLOOD WORK_____

EMERGENCY CONTACT NAME & NUMBER_____

BLOOD GROUP _____ALLERGIES_____

How did you hear about our clinic?_____

Have you ever had previous Naturopathic care?_____When_____

What for:_____

Was this successfully resolved?_____

**What is your MAIN reason for coming in today?**

_____

_____

_____

_____

**List other Health concerns that are troubling you & when these started:**

1)_____

2)_____

3)_____

4)_____

**Current medication** and reason for taking:

1)_____what for _____

2)_____what for _____

3)_____what for _____

4)_____what for _____

**Natural supplements** and reasons for taking**:**

1) _____what for _____

2) _____what for _____

3) _____what for _____

4) _____what for _____

List Surgical Operation and approximate date:

_____

_____

Major Accidents:

_____

_____

List any contagious diseases you may have come in contact with:

_____

**FAMILY HISTORY**:

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 | |

**Health History:**

What is your general **state of wellbeing** from 1-10? (10 is the highest) _____

What is your **level of commitment** to your wellbeing? 1-10? (10 is the highest) _____

On average, how would you rate your **energy level** from 1-10? (10 is the highest) _____

What is your general level of fitness? (10 is highest) _____

How would you rate your quality of sleep (10 is highest) _____

How would you rate your stress levels now? (10 is highest) _____

How would you rate your diet? (10 is highest) _____

**Life style factors**

Do you Exercise? **Y / N** if so how often?_____

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?

_____

_____

**Diet**

Are there any foods that you: **avoid**:_____

Are there any foods you have **reactions to**? _____

Do you **crave** any kids of foods?_____

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

Before Breakfast: _____

Breakfast:

_____Time:_____

_____

_____

_____

Morning Tea:

_____Time:_____

Lunch:

_____Time:_____

_____

_____

_____

Afternoon Tea:

_____Time:_____

Dinner

_____Time:_____

_____

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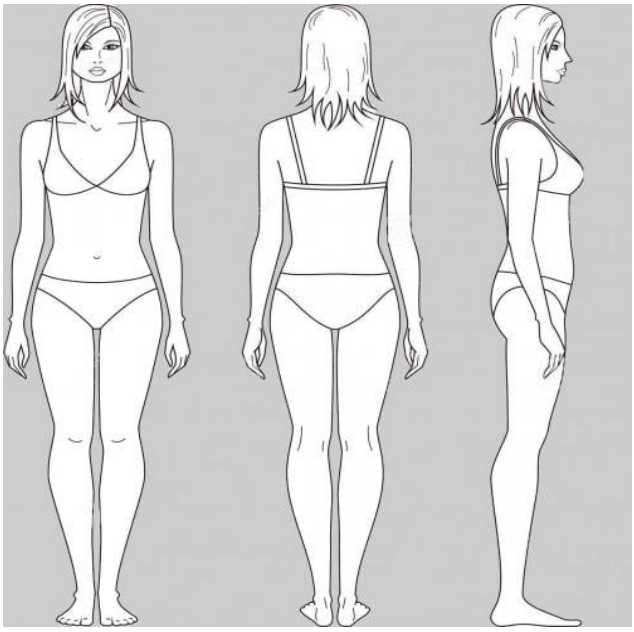
_____

Supper_____Time:_____

_____



_____
_____
_____
_____
_____

Do you consume the following and how much per day:

Coffee _____Tea_____

Soft drink _____ Sweets/Lollies_____

Cordial_____Fruit juice_____

Add sugar to foods/drinks _____

How many teaspoons per day? _____

Are you a smoker? _____
Do you drink alcohol? **Y / N** type_____
How often_____
Do you take recreational drugs? **Y / N**_____

Type_____Frequency_____

How much water do you drink a day_____

Is the water filtered/ bottled?_____

**Sleep**: (please circle appropriate)

No problems Problems falling asleep Problem staying asleep

Average hours of sleep you get _____ is this enough for you?_____

Are you a: light sleeper or heavy sleeper

Do you recall your dreams **Y / N** or occasionally

Do you have Sleep apnea **Y / N or** maybe Do you snore: **Y / N** or maybe

Do you wake up during the night? If so / how often _____ what time_____

What time do you go to sleep? _____

What time do you wake up in the morning? _____Waking tired?_____

**Teeth & Oral Health:**

last trip to the dentist_____ any prior dental diagnoses _____

number of amalgams_____ Implants,_____Root canals_____

any signs of bleeding on brushing _____ Any foods you avoid for dental reasons_____

_____

How would you describe your overall dental health:

_____

**Bowels**: (please circle appropriate)

frequency _____

Are there undigested food particles seen in the stool? _____

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_____

□Nausea on waking_____ □Irritable bowel_____ □Hemorrhoids_____

Other:_____

Please indicate what a regular bowel movement would look like for you. You may choose more than one.

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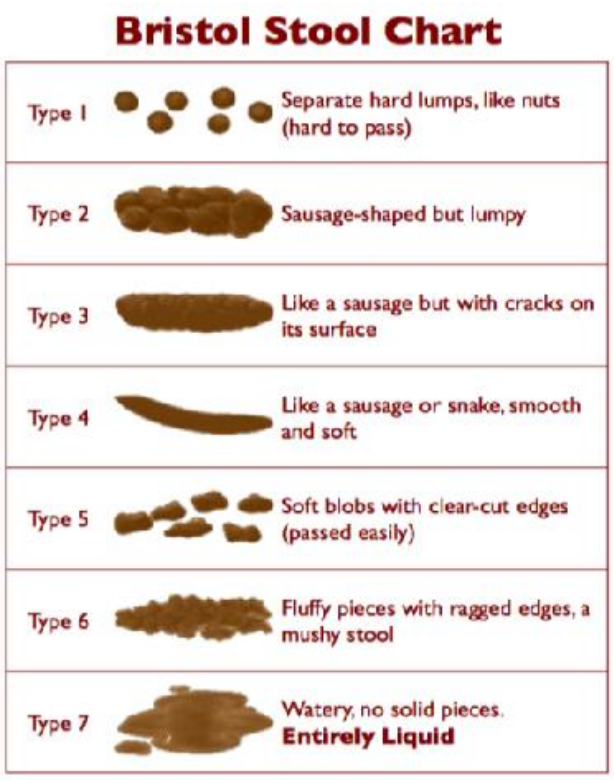

**Female Health:**
**Periods**:

Age of first period:_____

Have your periods stopped?_____

Are your cycles regular_____

Any spotting of bleeding between your periods _____

Do you have premenstrual syndrome (PMS)? _____

Regular, Irregular, length of cycle in days_____

Do you know then you are ovulating? _____ Day of Cycle_____

How many days do you bleed for: _____

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

Any Pain associated with periods: _____

Tampons, Pads, Other, What size used on heavy bleed days_____

(Please circle where applicable): Water retention Breast tenderness Irritability Depression

Headaches Migraines Anger Mood Swings Crying Bloating Acne Cravings Tired

Other_____

Last Pap smear:_____Results:_____

**Contraceptives**: Pill, Mirena, Implant, Other Length of time on this_____

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

□Weight loss_____ □Diet_____

□Disease Prevention_____ □Cardiovascular health_____

□Pre-conception care_____ □Energy_____

□Immune system_____ □Sports enhancement_____

Other:_____

Were you vaccinated? If so, any adverse reactions? Please list

_____

_____

Please indicate which, if any, of the following you have had either **Now (N)** or in the **Past (P)**:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Allergies | | Ear Infection | | Malaria | | Sexual abuse | |
| Abscesses | | Eczema | | Measles | | Sleeping Problems | |
| Alcoholism | | Emotional abuse | | Mental illness | | Small pox | |
| Anemia | | Epilepsy | | Migraine | | Strep throat | |
| Arthritis | | Fainting | | Miscarriage | | Stroke | |
| Asthma | | Fatigue | | Mono | | Syphilis | |
| Balance issues | | Fungal Infections | | Mumps | | Thyroid issues | |
| Bladder infections | | Gallstones | | Numbness or tingling | | Tonsillitis | |
| Broken bone | | Gas/bloating | | Parasites | | Tuberculosis | |
| Bronchitis | | Gout | | Pelvic Inflammatory Disease | | Varicose veins | |
| Cancer | | Hay fever | | Physical abuse | | Venereal disease | |
| Chicken pox | | Headache | | Pneumonia | | Vision issues | |
| Child abuse | | Heart disease | | Poor memory | | Warts | |
| Chronic Sore Throats | | Hemorrhoids | | Rape | | Weight issues | |
| Cold hands/feet | | Hepatitis | | Rectal bleeding | | Whooping cough | |
| Depression | | Herpes | | Rheumatic fever | | Worms | |
| Diabetes | | High blood pressure | | Ringing in ears | | Other: | |
| Diphtheria | | Jaundice | | Scarlet fever | | | |

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? _____

_____

Is there any other information you think is important to let me know? -

_____

Rate each of the following symptoms based upon your typical health profile for: □ Past 30 days □ Past 48 hours

**Point Scale**

0- Never or almost never have the symptoms
1- Occasionally have it, effect is not severe
2- Occasionally have it, effect is severe
3- Frequently have it, effect is not severe
4- Frequently have it, effect is severe

| | | |
|---|---|---|
| **Head** | _____ Headaches<br>_____ Faintness<br>_____ Dizziness<br>_____ Insomnia | **Total** _____ |
| **Eyes** | _____Watery or Itchy eyes<br>_____ Swollen, reddened or sticky eyelids<br>_____ Bags or dark circles under eyes<br>_____Blurred or tunnel vision (does not include near or farsightedness) | **Total** _____ |
| **Ears** | _____ Itchy ears<br>_____ Earaches, ear infections<br>_____ Drainage from ear<br>_____ Ringing in ears, hearing loss | **Total** _____ |
| **Nose** | _____ Stuffy nose<br>_____ Sinus problems<br>_____ Hay fever<br>_____ Sneezing attacks<br>_____Excessive mucus formation | **Total** _____ |
| **Mouth/ Throat** | _____ Chronic coughing<br>_____ Gagging, frequent need to clear throat<br>_____ Sore throat, hoarseness, loss of voice<br>_____ Swollen or discoloured tongue, gums, or lips<br>_____ Cancker sores | **Total** _____ |
| **Skin** | _____ Acne<br>_____ Hives, rashes, dry skin<br>_____ Hair loss<br>_____ Flushing, hot flashes<br>_____ Excessive sweating | **Total** _____ |
| **Heart** | _____Irregular or skipped heartbeat<br>_____ Rapid or pounding heartbeat<br>_____ Chest pain | **Total** _____ |
| **Lungs** | _____ Chest congestion<br>_____ Asthma, bronchitis<br>_____ Shortness of breath<br>_____ Difficulty breathing | **Total** _____ |
| **Digestive Tract** | _____ Nausea, vomiting<br>_____ Diarrhea<br>_____ Constipation<br>_____ Bloated feeling<br>_____ Belching, passing gas<br>_____Heartburn<br>_____ Intestinal/ Stomach pain | **Total** _____ |
| **Joints/ Muscles** | _____ Pain or aches in joints<br>_____ Arthritis<br>_____Stiffness or limitation of movement<br>_____ Pain or aches in muscles<br>_____Feeling of weakness or tiredness | **Total** _____ |
| **Weight** | _____ Binge eating/ drinking<br>_____ Craving certain foods<br>_____ Excessive weight<br>_____ Compulsive eating<br>_____ Water retention<br>_____ Underweight | **Total** _____ |
| **Energy/ Activity** | _____ Fatigue, sluggishness<br>_____ Apathy, lethargy<br>_____ Hyperactivity<br>_____ Restlessness | **Total** _____ |
| **Mind** | _____ Poor memory<br>_____ Confusion, poor comprehension<br>_____ Poor concentration<br>_____ Poor physical coordination<br>_____ Difficulty making decisions<br>_____ Suffering or stammering<br>_____ Slurred speech<br>_____ Learning disabilities | **Total** _____ |
| **Emotions** | _____ Mood swings<br>_____ Anxiety, fear, nervousness<br>_____ Anger, irritability, aggressiveness<br>_____Depression | **Total** _____ |
| **Other** | _____ Frequent illness<br>_____ Frequent or urgent urination<br>_____ Genital itch or discharge | **Total** _____ |

**Welcome to Envision health naturopathic clinic!**

## About us

At Envision Health Naturopathic clinic we want people to feel better. Our vision is to create a safe space for all our patient in which they can strive for their optimum health. We know that in today's works, striving for optimum health is not easy – its incredibly challenging. At Envision Health we work to empower our patient to feel the best they can feel. We aim to educate our patient so that they can make the most informed decisions about their care.

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopaths asses the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the bodies inherent healing capacity.

During your initial one hour consultation we will take a thorough case history and may perform, if deemed necessary, physical examination, live blood analysis, bio impedance analysis, iridology etc. Second visits are 45 minutes in length and may include a review of initial consultation signs and symptoms and comparative testing and or further testing.

Refill consultations are generally 20-30 minutes are to do a quick review on an already established treatment plan.

## 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_____