ENVISION HEALTH
PROVIDING ALTERNATIVE HEALTH SOLUTIONS

Male 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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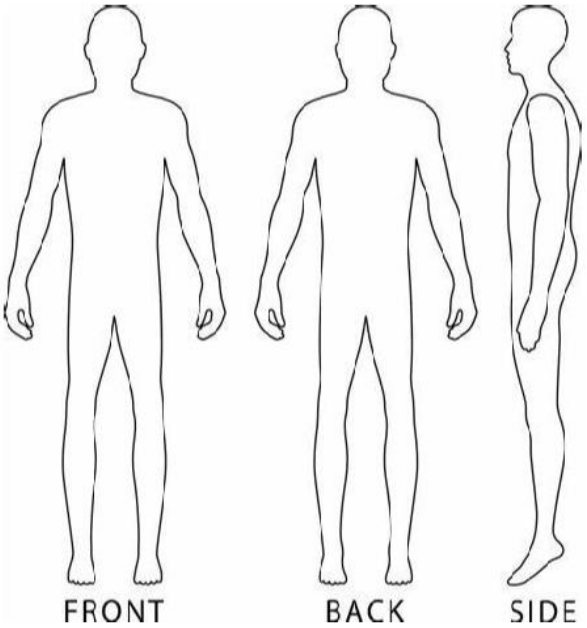
Supper_____Time:_____

_____



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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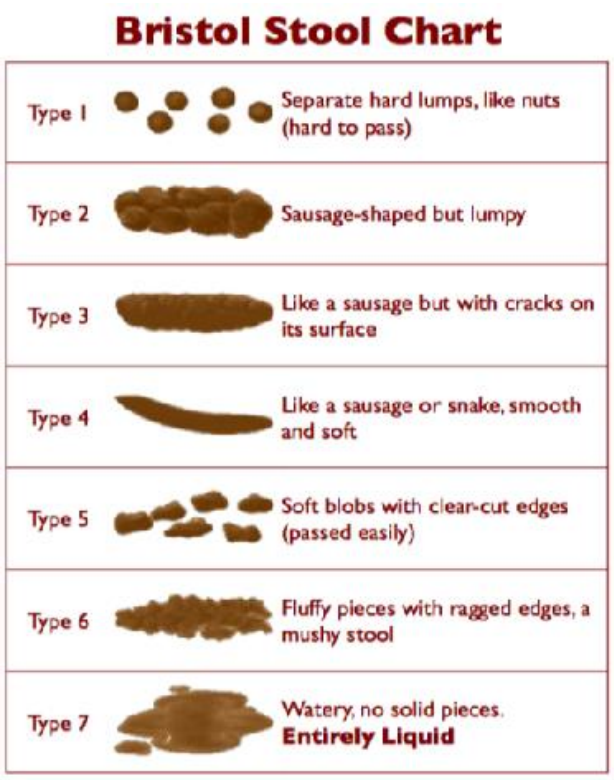

Male Health

Prostate Health:

No known problems

Prostatitis: yes_____ No_____ Occasionally

PSA Testing recently: yes_____ No_____ Not sure_____

Urinary flow: Strong continuous flow slow continuous flow interrupted flow (start stop)

Other_____

_____

_____

Sexual health:

No known problems:_____

erectile dysfunction:_____

lacking sex drive:_____

lack of erection in the mornings:_____

Vasectomy

Fertility

Are you and your partner trying to conceive? _____

Other:_____

_____

_____

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

Envision Health respectfully requires patients to provide 24-hours notice for appointment cancellations. Failure to do so may result in a cancellation fee that you well be responsible for.

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

Name_____Signature_____Date_____