Teens Patient Card

Date____________________

NAME:____

PARENTS NAME:____

ADDRESS:____

SUBURB:______________________________________POSTCODE:______________________

PARENTS PHONE:____

PARENTS EMAIL:____

DATE OF BIRTH_____/_____/_____Current age:________________Gender: ____________________

REFERRED BY ____________________________ DOCTOR _________________________________

DATE OF LAST PHYSICAL EXAMINATION & BLOOD WORK________________________________

EMERGENCY CONTACT NAME & NUMBER_______________________________________

BLOOD GROUP: _________

ALLERGIES:________________________________INTOLERANCES:______________________

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 ________________

Birth history:

____

____

Breastfed____________________ **Duration**______________________________

List Surgical Operation and approximate date:

____

____

Major Accidents:

____

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

____

VACCINATION HISTORY:
(this is a safe space)

Please check the vaccines your child has received and approximate date, if possible:

Measles, Mumps, Rubella (MMR)		Diptheria, Pertussis, Tetanus (DPT)		Chicken Pox	
Pneumococcus		Hepatitis A		Flu Shot	
HiB (Influenza B)		Hepatitis B		Polio	

Has your child had any adverse reactions after a vaccine? Please describe ___________________

____

Please indicate, if any, of the following, your child has had either **Now (N)** or in the **Past (P)**:

Allergies		Eczema		Mono		Strep throat	
Abscesses		Emotional abuse		Mumps		Tonsillitis	
Asthma		Epilepsy		Parasites		Tuberculosis	
Bed Wetting		Eye Infections		Physical abuse		Unusual Fears	
Bladder infections		Fatigue		Pneumonia		Vision issues	
Broken bone		Fungal Infections		Rectal bleeding		Vomiting	
Bronchitis		Gas/bloating		Rheumatic fever		Walking Problems	
Chicken Pox		Growing Pains		Ringing in ears		Warts	
Chronic Sore Throats		Headache		Scarlet fever		Whooping cough	
Cradle cap		Hemorrhoids		Sexual abuse		Worms	
Croup		Herpes		Sleeping Problems		Yeast infections	
Diarrhea		Lice		Small pox		Other:	
Diphtheria		Measles		Speech problems			
Ear Infection		Migraine		Stomach Aches			

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) ____

LIFESTYLE FACTORS:

What sports do you play and how often?____

Hobbies, what do you enjoy doing?

____

____

What are your responsibilities?____

Do you enjoy school?____

Do you have family or friends that you can talk to about things concerning you?

____

____

DIET:

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

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

Do you avoid eating lunch at school?____

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:_________

____

____

____

Supper____Time:_________

____

Please indicate any areas of concern:

Do you consume the following and how much per day:

Coffee ____________Tea_______________

Soft drink _________ Sweets_____________

Energy drinks: ___________

Fried foods _______________

Cordial___________Fruit juice_________

Add sugar to foods/drinks? _________________

How much water do you drink a day___________

is the water filtered/ bottled?_________________

Other Information:

____
____
____
____

Screen time: How much screen time daily? ____

Week days:

____

Weekends:

____

Mood/temperament:

____
____
____

SLEEP: (please circle appropriate)

Problems falling asleep Problem staying asleep

What time do you go to sleep? ____

What time do you wake up in the morning? _____________________Waking tired?_____________

Average hours of sleep you get ________________________ is this enough for you?___________

Are you a: light sleeper or heavy sleeper

Jaw clenching ____________ Mouth or nose breather?______________________________

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________________

TEETH & ORAL HEALTH:

last trip to the dentist_____________ any prior dental diagnoses ______________________

number of amalgams_____________ Implants,____________ Root canals_____________

Braces____________________ 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 have 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.

Bristol Stool Chart

Type 1	Separate hard lumps, like nuts (hard to pass)
Type 2	Sausage-shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear-cut edges (passed easily)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. **Entirely Liquid**

Other:

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)?

length of cycle in days (from 1st day to period until next 1st day of next period)

How many days is your period:

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

Any Pain associated with periods:

Tampons, Pads, Other,

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

Headaches Migraines Anger Mood Swings Crying Bloating Acne Cravings Tired

Other____

Contraceptives: Pill, 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_____________________ Mood management __________________

Immunisation support __________________ Energy_____________________________

Immune system________________________ Sports enhancement__________________

Other:____

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

____

What are you willing to do to achieve 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? -

____

____

____

____

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 – it's 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 assess the whole person, considering the individual's physical, mental, emotional and spiritual aspects. Gentle, non-invasive techniques are used 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, bioimpedance 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 will be responsible for.

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

Name______________________Signature__________________________Date______________