Invitation to Health
256 Henry Parry Drive
Wyoming NSW 2250
Ph: 4322 0700

Patient Intake Form

Welcome to ITH this is the first step on your path to wellness and we look forward to meeting with you in person.

We have created this comprehensive intake form for you to fill out in advance of coming to see us. We realise it might take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, about your current medical concerns and reasons for seeking our help. Having all this information on paper will be very helpful when you come in, and we will review this together during your medical or nutritional consultation. We have learned that it is often hard for our patients to remember everything when sitting in front of us!

Patient Information

Title (please circle) : Mr Mrs Miss Ms Master Dr Other ….

Name:		Date:
Age:	DOB:	Gender:
Occupation:		
Address Details:		
Street No. and Name:		
Suburb:	State:	Postcode:
Home Phone:		
Mobile Phone:	Work Phone:	
Email Address:		
Permission to leave a message on your answering machine or send an SMS:	Yes ☐	No ☐
Emergency Contact Name:	Relationship:	
Emergency Contact Phone Number:		
Next of Kin:	Relationship	
Next of Kin Contact Phone Number:		
Medicare Number:	**Position Number:**	**Medicare Expiry Date:**
DVA Gold/White Number:	DVA Expiry Date:	
Pension/Health Care Card Number:	Health Care Card Expiry Date:	Pensioner: Yes/No

Preferred Method of contact for preventative care & early case detection reminders (eg immunisations, annual health checks, skin checks and pap smears) :

SMS to Mobile Phone: ☐ Message left on answering machine ☐ In writing ☐

Preferred Method of contact to confirm appointments:

SMS to Mobile phone: ☐ Message left on answering machine: ☐

TO HELP THE PRACTICE PROVIDE APPROPRIATE HEALTH CARE, ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?

☐ ABORIGINAL ☐ NEITHER ABORIGINAL OR TORRES STRAIT ISLANDER

☐ TORRES STRAIT ISLANDER ` ☐ BOTH ABORIGINAL AND TORRES STRAIT ISLANDER

PATIENT CONSENT **Circle if applicable only**

I ______________________________(Parent/Guardian)understand that the information given to my treating doctor/therapist during my consultation is recorded by the doctor/therapist in my medical file. I give permission for information in my file to be forwarded to other medical persons if it is seen to be necessary for my health. I understand that all information in my file can only be accessed in agreement with my treating doctor on the basis that confidentiality and protection of privacy is assured.

Signed ______________________________ Today's Date: ______________________________________

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List Medications:

MEDICATION	REASON FOR USE

Allergy Information:

MEDICATION/SUPPLEMENT/FOOD	REACTION

☐ PROLONGED OR REGULAR USE OF NSAIDS (ADVIL, NUROFEN)

☐ PROLONGED USE OF ACID BLOCKING DRUGS (LOSEC, NEXIUM, PARIET)

☐ USE OF STERIODS (PREDNISONE, INHALERS) IN THE PAST

☐ PROLONGED USE OF ANTIBIOTICS

☐ PROLONGED USE OF ANTIDEPRESSANTS

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Previous Operations:

DATE	CONDITION/REASON

Preventative/Diagnostic Testing:

CHECK BOX IF YES AND PROVIDE DATE

☐ BONE DENSITY ____________________
☐ COLONOSCOPY ____________________
☐ CARDIAC STRESS TEST ____________________
☐ HEMOCCULT TEST-STOOL TEST FOR BLOOD ____________________

MEN'S PREVENTATIVE TESTING
CHECK BOX IF YES AND PROVIDE DATE

☐ LAST PSA ____________________
PSA LEVEL ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10
☐ LAST PROSTATE EXAM (RECTAL) __________
RESULTS ____________________

WOMEN'S PREVENTATIVE TESTING
CHECK BOX IF YES AND PROVIDE DATE

☐ LAST MAMMOGRAM ____________________
☐ NEED A BIOPSY? DATE ____________________
☐ PAP TEST DATE ____________________
☐ NORMAL ☐ ABNORMAL

Preventative Health:

Immunisations	**Yes**	**No**	**Month/Year**	
Tetanus Whooping cough				Booster recommended every 10 years with Pertussis (whooping cough) once as adult
Flu Vaccine				
Pneumonia vaccine				Recommended once at age 65 or earlier based on chronic health problems.

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Past and Current Medical History

CHECK BOX IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE CONDITIONS BELOW, EITHER PRESENTLY OR IN THE PAST (PRIOR TO 6 MONTHS)

GASTROINTESTINAL

- ☐ IRRITABLE BOWEL SYNDROME
- ☐ INFLAMMATORY BOWEL DISEASE
- ☐ PEPTIC ULCER
- ☐ GORD (REFLUX)
- ☐ COELIAC DISEASE
- ☐ COLONOSCOPY
  WHEN ____________________
- ☐ OTHER

____

CARDIOVASCULAR

- ☐ HEART ATTACK
- ☐ STROKE
- ☐ ELEVATED CHOLESTEROL
- ☐ ARRYTHMIA (IRREGULAR HEART RATE)
- ☐ HIGH BLOOD PRESSURE
- ☐ RHEUMATIC FEVER
- ☐ OTHER

____

METABOLIC/ENDOCRINE

- ☐ INSULIN RESISTANCE
- ☐ HYPOTHYROIDISM (LOW THYROID)
- ☐ HYPERTHYROIDISM (OVERACTIVE)
- ☐ POLYCYSTIC OVARIAN SYNDROME
- ☐ BULIMIA
- ☐ ANOREXIA
- ☐ BINGE EATING DISORDER
- ☐ TYPE 1 DIABETES
- ☐ TYPE 2 DIABETES
- ☐ OTHER

____

CANCER

- ☐ LUNG CANCER
- ☐ BREAST CANCER
- ☐ COLON CANCER
- ☐ OVARIAN CANCER
- ☐ PROSTATE CANCER
- ☐ SKIN CANCER
- ☐ OTHER _________________

INFLAMMATORY/ AUTOIMMUNE

- ☐ CHRONIC FATIGUE SYNDROME
- ☐ GLANDULAR FEVER
- ☐ HASHIMOTO OR GRAVES
- ☐ RHEUMATOID ARTHRITIS
- ☐ LUPUS/SLE
- ☐ IMMUNE DEFICIENCY DISEASE
- ☐ FOOD ALLERGIES
- ☐ ENVIRONMENT ALLERGIES
- ☐ MULTIPLE CHEMICAL SENSITIVITIES
- ☐ LATEX ALLERGY
- ☐ OTHER AUTOIMMUNE

____

SKIN DISEASES

- ☐ ECZEMA
- ☐ PSORIASIS
- ☐ ACNE
- ☐ MELANOMA
- ☐ SKIN CANCER
- ☐ OTHER _________________

GENITAL AND URINARY

- ☐ KIDNEY STONES
- ☐ GOUT
- ☐ INTERSTITIAL CYSTITIS
- ☐ FREQUENT URINARY TRACT INFECTIONS
- ☐ FREQUENT YEAST INFECTIONS
- ☐ ERECTILE DYSFUNCTION
- ☐ OR SEXUAL DYSFUNCTION

MUSCULOSKELETAL OR PAIN

- ☐ OSTEOARTHRITIS
- ☐ FIBROMYALGIA
- ☐ CHRONIC PAIN
- ☐ OTHER _________________

RESPIRATORY DISEASES

- ☐ ASTHMA
- ☐ CHRONIC SINUSITIS
- ☐ BRONCHITIS
- ☐ EMPHYSEMA
- ☐ PNEUMONIA
- ☐ TUBERCULOSIS
- ☐ SLEEP APNOEA
- ☐ OTHER __________________

NEUROLOGIC/MOOD

- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ BIPOLAR DISORDER
- ☐ SCHIZOPHRENIA
- ☐ HEADACHES
- ☐ MIGRAINES
- ☐ ADD/ADHD
- ☐ AUTISM
- ☐ MILD COGNITIVE IMPAIRMENT
- ☐ PARKINSON'S DISEASE
- ☐ MULTIPLE SCLEROSIS
- ☐ SEIZURES
- ☐ OTHER ________________

Further Medical History

YOUR CHILDHOOD HISTORY

- ☐ LOTS OF SUGAR AS A CHILD
- ☐ EAR INFECTIONS

FOR WOMEN - ***OBSTETRIC HISTORY***

- ☐ PREGNANCIES
  CAESAREAN____

MENOPAUSE HISTORY

- ☐ MENOPAUSE, AGE OF LAST PERIOD _____________

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☐ RECURRENT STREP THROAT
☐ LOTS OF ANTIBIOTICS
☐ STOMACH ACHES
☐ OTHER CHILDHOOD ILLNESSES
____

DENTAL HISTORY
☐ LOTS OF CAVITIES AS A CHILD
☐ SILVER MERCURY FILLINGS
HOW MANY? _________
☐ GOLD FILLINGS
☐ ROOT CANALS
☐ IMPLANTS
☐ TOOTH PAIN
☐ BLEEDING GUMS
☐ GINGIVITIS
☐ FLOSS REGULARLY

VAGINAL DELIVERIES____
MISCARRIAGE____
ABORTION____
LIVING CHILDREN____
☐ POST PARTUM DEPRESSION
☐ PRE ECLAMPSIA
☐ GESTATIONAL DIABETES
☐ BABY OVER 8 POUNDS
☐ BREAST FEEDING
HOW LONG?_____

☐ HORMONE REPLACEMENT THERAPY
☐ CURRENTLY?
YEARS?___
☐ PAST? WHEN?_____

Family History

Family history - have any members of your family had:

☐ Diabetes ☐ Depression
☐ Asthma ☐ Stroke
☐ Heart Disease ☐ Cancer - Type
☐ Mental illness ☐ Smoker
☐ Other

Lifestyle and Self-Care

SMOKING

☐ CURRENTLY SMOKING

HOW MANY YEARS? ______________
PACKS PER DAY? _________________
ATTEMPTS TO QUIT? _____________

☐ PREVIOUS SMOKING

HOW MANY YEARS?______________
PACKS PER DAY? ________________
2ND HAND SMOKE EXPOSURE______

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Social & Personal History (tick all that apply)

ETHNICITY: AUSTRALIA IS A GENUINELY MULTICULTURAL SOCIETY. TO TAILOR APPROPRIATE CARE, ENCOURAGE UNDERSTANDING AND APPRECIATION BETWEEN PEOPLE FROM DIFFERENT NATIONALITIES AND BACKGROUNDS – DO YOU IDENTIFY AS SOMEONE FROM A CULTURALLY AND /OR LINGUISTIC DIVERSE BACKGROUND?

YES ☐ NO ☐

IF YES, PLEASE GIVE DETAIL: ____

____

EDUCATION: HOW MANY YEARS OF EDUCATION DO YOU HAVE?

☐ NO HIGH SCHOOL DIPLOMA
☐ COLLEGE DEGREE
☐ HIGH SCHOOL OR EQUIVALENT
☐ GRADUATE OR PROFESSIONAL DEGREE
☐ EDUCATION BEYOND HIGH SCHOOL, BUT HAVE NO COMPLETED COLLEGE BACHELOR'S DEGREE

TICK ALL THAT APPLY:

CURRENT EMPLOYMENT STATUS:

☐ WORKING FULL -TIME
☐ WORKING PART-TIME
☐ RETIRED
☐ ON MEDICAL LEAVE OR DISABLED
☐ UNEMPLOYED, LOOKING FOR WORK
☐ NOT EMPLOYED DUE TO OTHER RESPONSIBILITIES (IE RAISING CHILDREN, KEEPING HOUSE, STUDENT)
☐ OTHER, PLEASE SPECIFY:

____

MARITAL STATUS:

☐ MARRIED, SPOUSE IN HOUSEHOLD
☐ MARRIED, SPOUSE NOT IN HOUSEHOLD
☐ SEPARATED
☐ WIDOWED
☐ DIVORCED
☐ SINGLE
☐ NEVER MARRIED
☐ GAY/LESBIAN
☐ LONG TERM PARTNERSHIP

CHILDREN:

CHILD'S NAME	AGE	GENDER

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SLEEP

AVERAGE NUMBER OF HOURS YOU SLEEP PER NIGHT ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6
WHAT TIME DO YOU GO TO SLEEP? ________________ WAKE UP? ________________

☐ TROUBLE FALLING ASLEEP
☐ STILL FEEL TIRED IN THE MORNING
☐ WAKE UP DURING THE NIGHT AND CAN'T FALL BACK TO SLEEP
☐ SNORING IS AN ISSUE. YOU OR YOUR PARTNER? ________________________________
☐ RELY ON SLEEPING PILLS

Exercise – Current Exercise Programme

ACTIVITY	TYPE	HOW OFTEN EACH WEEK	HOW LONG
STRETCHING:			
CARDIO/AEROBICS:			
STRENGTH:			
OTHER (YOGA, PILATES ETC):			
SPORTS OR LEISURE ACTIVITY:			

RATE YOUR LEVEL OF MOTIVATION FOR INDLUDING EXERCISE IN YOUR LIFE? ☐ LOW ☐ MEDIUM ☐ HIGH
LIST PROBLEMS THAT LIMIT ACTIVITY: ____
DO YOU FEEL UNUSUALLY FATIGUED AFTER EXERCISE? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE: ____
DO YOU USUALLY SWEAT WHEN EXERCISING? ☐ YES ☐ NO

Environmental or Other Exposures and Detox Assessment

ADVERSE REACTION TO:

☐ CAFFEINE
☐ IRRITABLE ☐ WIRED ☐ ACHES & PAINS
☐ MONOSODIUM GLUTAMATE (MSG)
☐ ASPARTAME (NUTRASWEET)
☐ BANANAS ☐ GARLIC ☐ ONION ☐ CHEESE
☐ CITRUS FOODS ☐ CHOCOLATE ☐ ALCOHOL ☐ RED WINE
☐ SULPHITE CONTAINING FOODS
(WINE, DRIED FRUIT, SALAD BARS)
☐ PRESERVATIVES (SODIUM BENZOATE)
☐ OTHER ____________________________

HISTORY OF:

☐ JAUNDICE (TURNING YELLOW)
☐ GILBERT'S SYNDROME OR A LIVER DISORDER
EXPLAIN ____________________

EXPOSURE TO HARMFUL CHEMCIALS SUCH AS:
☐ HERBICIDES
☐ INSECTICIDES (FREQUENT VISITS OF EXTERMINATOR)
☐ PESTICIDES
☐ ORGANIC SOLVENTS
☐ HEAVY METALS
☐ OTHER ____________________________

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YOU ARE EFFECTED BY:

- ☐ CIGARETTE SMOKE
- ☐ PERFUMES/COLOGNES
- ☐ AUTO EXHAUST FUMES
- ☐ OTHER ____________________________

IN YOUR WORK OR HOME ENVIRONMENT, ARE YOU EXPOSED TO:

- ☐ CHEMICALS
- ☐ MOULD

CHEMICAL NAME/DATE/LENGTH OF EXPOSURE
____
____
____

- ☐ DRY CLEAN YOUR CLOTHES FREQUENTLY
- ☐ LIVED OR WORKED IN A DAMP OR MOULDY ENVIRONMENT OR HAD OTHER MOULD EXPOSURE
- ☐ DO YOU HAVE ANY PETS OR FARM ANIMALS _______________________________________
- ☐ ELECTROMAGNETIC RADIATION
- ☐ WORK WITH OIL BASED PAINT - ARTIST OR PAINTER
- ☐ HISTORY OF DRINKING PROBLEM (SEE LIFESTYLE SECTION FOR DETAILED QUESTIONS)

STRESS/COPING CHECK ALL THAT APPLY

- ☐ I HAVE BEEN IN COUNSELLING IN THE PAST
- ☐ I AM CURRENTLY IN THERAPY. DESCRIBE: ____
- ☐ I HAVE AN EXCESSIVE AMOUNT OF STRESS
- ☐ I HAVE TROUBLE HANDLING THE STRESS IN MY LIFE
- ☐ DAILY STRESSORS: RATE ON SCALE OF 1-10 (10 IS THE WORST)

WORK __ FAMILY ___ SOCIAL ___ FINANCES ___ HEALTH ___ OTHER ___

☐ I PRACTICE MEDITATION OR A RELAXATION TECHNIQUE. HOW OFTEN? _____

CHECK ALL THAT APPLY:

☐ YOGA ☐ MEDITATION ☐ IMAGERY ☐ BREATHING ☐ TAI CHI ☐ PRAYER ☐ OTHER: _________

How did you find out about ITH?

Friend or Family ☐ Website ☐ Search Engine ☐
Media ☐ Phone Book ☐
Other Health Professional ☐ Other: ________________

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Current Health

Reason for this Visit? Tick all that apply

☐ General health, prevention and wellbeing
☐ Chronic illness/condition (heart disease, diabetes, chronic pain of > 3 months etc)
specify:____________________________________
☐ Acute illness – specify: ________________________________
☐ Surgery-related – specify: ______________________________
☐ Other – specify: __________________________________

What type of Service are you here for? (Check all that apply)

☐ GP Consult	☐ Biomedical Consult
☐ Nurse Consult	☐ Traditional Chinese Medicine
☐ Acupuncture	☐ Osteopathy
☐ Kinesiology	☐ Psychology
☐ Nutrition	☐ Naturopathy
☐ Bach Flowers	☐ Other

Medical History

What brings you to Invitation to Health?

If you had 3 wishes for your visit today, what would they be?

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SYMPTOM REVIEW – Please tick if you have any of the following symptoms:

SKIN PROBLEMS
- ☐ ACNE
- ☐ ATHLETE'S FOOT
- ☐ BUMPS BACK OF ARMS
- ☐ CELLULITE
- ☐ DANDRUFF
- ☐ DARK CIRCLES UNDER EYES
- ☐ EARS GET RED
- ☐ EASY BRUISING
- ☐ ECZEMA
- ☐ HERPES - GENITAL
- ☐ COLD SORES
- ☐ HIVES
- ☐ JOCK ITCH
- ☐ CHANGE IN MOLES
- ☐ OILY SKIN
- ☐ PSIORIASIS
- ☐ RASH
- ☐ SENSITIVE TO BITES
- ☐ SHINGLES
- ☐ SKIN ITCHING
- ☐ SKIN DRYNRESS
- ☐ STRONG BODY ODOUR

DIGESTION
- ☐ BLOATING AFTER EATING
- ☐ BLOOD IN STOOLS
- ☐ BURPING
- ☐ CONSTIPATION
- ☐ ANAL ITCHING
- ☐ TROUBLE CHEWING
- ☐ DIARRHEA
- ☐ DIFFICULTY SWALLOWING/PAINFUL
- ☐ DRY MOUTH
- ☐ FISSURES
- ☐ HEARTBURN (REFLUX)
- ☐ HAEMORRHOIDS

INTOLERANCE TO:
- ☐ LACTOSE
- ☐ ALL MILK PRODUCTS
- ☐ GLUTEN
- ☐ CORN
- ☐ EGGS
- ☐ FATTY FOODS
- ☐ OTHER CLICK HERE TO ENTER TEXT.

HEAD, EYES & EARS
- ☐ DISTORTED SMELL
- ☐ DISTORTED TASTE
- ☐ BAD BREATH
- ☐ EAR FULLNESS
- ☐ EAR PAIN
- ☐ EAR RINGING
- ☐ HEARING PROBLEMS
- ☐ RECURRENT SORE THROAT
- ☐ HOARSENESS
- ☐ EYE PAIN/IRRITATION
- ☐ VISION DISTURBANCE
- ☐ SINUS
- ☐ MIGRAINE
- ☐ HEADACHE
- ☐ NOISE SENSITIVE
- ☐ JAW PAIN

NAILS
- ☐ BITTEN
- ☐ BRITTLE
- ☐ FUNGUS
- ☐ RIDGES
- ☐ THICKENED
- ☐ WHITE SPOTS/LINES

MUSCLE/BONE
- ☐ MUSCLE TWITCHING
- ☐ MUSCLE PAIN
- ☐ JOINT PAIN OR SWELLING
- ☐ JOINT STIFFNESS
- ☐ BACK PAIN

MOOD/NERVES
- ☐ DIFFICULTY CONCENTRATING
- ☐ DIFFICULTY WITH BALANCE
- ☐ DIFFICULTY WITH JUDGEMENT
- ☐ DIFFICULTY WITH MEMORY
- ☐ DIZZINESS (SPINNING)
- ☐ SUICIDAL THOUGHTS
- ☐ DEPRESSION
- ☐ NUMBNESS
- ☐ PANIC ATTACKS
- ☐ ANXIETY
- ☐ OTHER PHOBIAS
- ☐ PARANOIA
- ☐ HALLUCINATIONS
- ☐ SEIZURES
- ☐ TREMOR

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ BREATHLESSNESS
- ☐ PALPITATIONS
- ☐ PAIN IN CALVES
- ☐ SWOLLEN ANKLES
- ☐ VARICOSE VEINS
- ☐ LIGHT HEADEDNESS
- ☐ FAINTING

RESPIRATORY
- ☐ SNORING
- ☐ COUGH
- ☐ COUGHING UP BLOOD
- ☐ HAYFEVER
- ☐ SINUS FULLNESS
- ☐ NASAL STUFFINESS
- ☐ NOSE BLEEDS
- ☐ POST NASAL DRIP
- ☐ SHORTNESS OF BREATH
  - ☐ AT REST
  - ☐ WITH EXERCISE

ENDOCRINE/IMMUNE
- ☐ COLD HANDS/FEET
- ☐ COLD/HEAT INTOLERANCE
- ☐ FATIGUE
- ☐ WEIGHT GAIN
- ☐ GET SICK A LOT
- ☐ SWOLLEN LYMPH NODES
- ☐ HAIR LOSS

URINARY
- ☐ HESITANCY
- ☐ FREQUENT UTI
- ☐ PAIN/BURNING
- ☐ URGENCY
- ☐ LEAKING
- ☐ BLOOD IN URINE

MALE REPRODUCTIVE
- ☐ DISCHARGE FROM PENIS
- ☐ EJACULATION PROBLEM
- ☐ GENITAL PAIN
- ☐ POOR LIBIDO (LOW SEX DRIVE)
- ☐ IMPOTENCE
- ☐ LUMPS IN TESTICLES

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SYMPTOM REVIEW CONTINUED – PLEASE TICK IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

- ☐ YELLOW EYES/SKIN
- ☐ ABDOMINAL PAIN
- ☐ MUCOUS IN STOOLS
- ☐ NAUSEA
- ☐ STRONG STOOL ODOR
- ☐ UNDIGESTED FOODS IN STOOLS
- ☐ VOMITING
- ☐ UNINTENTIONAL WEIGHT LOSS
- ☐ CAR SICKNESS

FEMALE REPRODUCTIVE

- ☐ BREAST CYSTS
- ☐ BREAST TENDERNESS
- ☐ OVARIAN CYST
- ☐ POOR LIBIDO (SEX DRIVE)
- ☐ PELVIC PAIN
- ☐ IRRITABILITY
- ☐ INFERTILITY
- ☐ VAGINAL DISCHARGE
- ☐ VAGINAL ITCH
- ☐ SPOTTING

PREMENSTRUAL

- ☐ BLOATING
- ☐ BREAST TENDERNESS
- ☐ MOOD SWINGS
- ☐ FOOD CRAVINGS
- ☐ SLEEP CHANGE
- ☐ FATIGUE
- ☐ IRRITABILITY

MENSTRUAL

- ☐ CRAMPS
- ☐ HEAVY PERIODS
- ☐ IRREGULAR PERIODS
- ☐ NO PERIODS
- ☐ FREQUENT URINATION
- ☐ CHANGE IN BOWEL HABIT WITH MENSES

MENOPAUSE

- ☐ HOT FLUSHES
- ☐ VAGINAL PAIN
- ☐ CONCENTRATION
- ☐ VAGINAL DRYNESS
- ☐ PAINFUL SEX
- ☐ DECREASED LIBIDO
- ☐ WEIGHT GAIN
- ☐ SLEEP DISTURBANCE

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Nutrition and Diet

NUTRITION HISTORY

HAVE YOU EVER HAD A NUTRITION CONSULTATION? ☐ YES ☐ NO

HAVE YOU MADE ANY CHANGES IN YOUR EATING HABIT BECAUSE OF YOUR HEALTH ☐ YES ☐ NO

DESCRIBE: ______________________ ____
DO YOU CURRENTLY FOLLOW A SPECIAL DIET OR NUTRITIONAL PROGRAM? ☐ YES ☐ NO
CHECK ALL THAT APPLY
☐ LOW FAT ☐ LOW CARBOHYDRATES ☐ HIGH PROTEIN ☐ LOW SODIUM ☐ DIABETIC
☐ NO DAIRY ☐ NO WHEAT ☐ GLUTEN RESTRICTED ☐ VEGETARIAN ☐ VEGAN
SPECIFIC PROGRAM FOR WEIGHT LOSS/MAINTENANCE TYPE: ____
☐ OTHER ____
HOW OFTEN DO YOU WEIGH YOURSELF? ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ RARELY ☐ NEVER
DO YOU AVOID ANY PARTICULAR FOODS? ☐ YES ☐ NO
IF YES, TYPES AND REASON ____
DO YOU GROCERY SHOP? ☐ YES ☐ NO, IF NO WHO DOES THE SHOPPING? _____________________________
DO YOU READ FOOD LABELS? ☐ YES ☐ NO ____
DO YOU COOK? ☐ YES ☐ NO, IF NO WHO DOES THE COOKING? ____
HOW MANY MEALS DO YOU EAT OUT PER WEEK? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 MEALS PER WEEK.

CHECK ALL THE FACTORS THAT APPLY TO YOUR CURRENT LIFESTYLE AND EATING HABITS:

☐ FAST EATER
☐ LATE NIGHT EATING
☐ TRAVEL FREQUENTLY
☐ ERRACTIC EATING PATTERNS
☐ DISLIKE HEALTHY FOOD
☐ NON AVAILABILITY OF HEALTHY FOODS
☐ EAT TOO MUCH
☐ TIME CONSTRAINTS
☐ POOR SNACK CHOICES
☐ EAT TOO MUCH UNDER STRESS
☐ EAT TOO LITTLE UNDER STRESS
☐ RELIANCE ON CONVENIENCE ITEMS
☐ SIGNIFICANT OTHER OR FAMILY MEMBERS DON'T LIKE HEALTHY FOODS
☐ SIGNIFICANT OTHER OR FAMILY MEMBERS HAVE SPECIAL DIETARY NEEDS OR FOOD PREFERENCES
☐ LOVE TO EAT
☐ EAT BECAUSE I HAVE TO
☐ HAVE A NEGATIVE RELATIONSHIP WITH FOOD
☐ STRUGGLE WITH EATING ISSUES
☐ EMOTIONAL EATER (EAT WHEN SAD, LONELY, DEPRESSED)
☐ EAT IN THE MIDDLE OF THE NIGHT
☐ CONFUSED ABOUT NUTRITION ADVICE
☐ DON'T CARE TO COOK

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Invitation to Health
256 Henry Parry Drive
Wyoming NSW 2250
Ph: 4322 0700

Patient Intake Form

Nutritional Supplements (vitamins, herbs, homeopathy)

SUPPLEMENT/BRAND	REASON FOR USE

Readiness to Change

RATE ON A SCALE OF: 5 (VERY WILLING) TO 1 (NOT WILLING)

IN ORDER TO IMPROVE YOUR HEALTH, HOW WILLING ARE YOU TO:

SIGNIFICANTLY MODIFY YOUR DIET:
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

KEEP A RECORD OF EVERYTHING YOU EAT EACH DAY:
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

MODIFY YOUR LIFESTYLE (EG WORK DEMANDS, SLEEP HABITS):
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

ENGAGE IN REGULAR EXERCISE:
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

TAKE SEVERAL NUTRITIONAL SUPPLEMENTS EACH DAY:
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

PRACTICE A RELAXATION TECHNIQUE:
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

HOW CONFIDENT ARE YOU OF YOUR ABILITY TO ORGANISE AND FOLLOW THROUGH ON THE ABOVE HEALTH RELATED ACTIVITIES?
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

AT THE PRESENT TIME, HOW SUPPORTIVE DO YOU THINK THE PEOPLE IN YOUR HOUSEHOLD WILL BE TO YOUR IMPLEMENTING THE ABOVE CHANGES?
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

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COMMENTS:
CANCELLATION POLICY AGREEMENT TODAY'S DATE: TO: