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

Patient Intake Form
Child

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 realize 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 Miss Master (Please circle one)		
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:**
Pension/Health Care Card Number:	Health Care Card Expiry Date:	Pensioner: Yes/No

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 & 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

Birth History:

Delivery: Vaginal OR LSCS ? (please circle)

Please list any birth complications?

Did you or do you have any concerns around milestones being reached?

Has a third party expressed concern in your child's development? (eg Preschool/school/carer)

Allergy Information:

MEDICATION/SUPPLEMENT/FOOD	REACTION

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Previous Hospitalisations & Operations:

DATE	CONDITION/REASON

Fully immunised: ☐ YES ☐ NO

Please list any vaccines not received:

Past 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

☐ RHEUMATIC FEVER
☐ OTHER
_____

SKIN DISEASES

☐ ECZEMA
☐ PSORIASIS
☐ ACNE
☐ OTHER _____

METABOLIC/ENDOCRINE

☐ INSULIN RESISTANCE
☐ HYPOTHYROIDISM (LOW THYROID)
☐ HYPERTHYROIDISM (OVERACTIVE)
☐ BULIMIA
☐ ANOREXIA
☐ BINGE EATING DISORDER
☐ TYPE 1 DIABETES
☐ OTHER
_____

INFLAMMATORY/ AUTOIMMUNE

☐ GLANDULAR FEVER
☐ RHEUMATOID ARTHRITIS
☐ LUPUS/SLE
☐ IMMUNE DEFICIENCY DISEASE
☐ FOOD ALLERGIES
☐ ENVIRONMENT ALLERGIES

NEUROLOGIC/MOOD

☐ DEPRESSION
☐ ANXIETY
☐ HEADACHES
☐ MIGRAINES
☐ ADD/ADHD
☐ AUTISM
☐ SEIZURES

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☐ MULTIPLE CHEMICAL SENSITIVITIES
☐ LATEX ALLERGY
☐ OTHER AUTOIMMUNE

GENITAL AND URINARY
☐ FREQUENT URINARY TRACT INFECTIONS
☐ FREQUENT YEAST INFECTIONS

MUSCULOSKELETAL OR PAIN

☐ CHRONIC PAIN
☐ OTHER _____

☐ OTHER _____

RESPIRATORY DISEASES
☐ ASTHMA
☐ CHRONIC SINUSITIS
☐ BRONCHITIS
☐ PNEUMONIA
☐ TUBERCULOSIS
☐ SLEEP APNOEA
☐ OTHER _____

Further Medical History

YOUR CHILDHOOD HISTORY
☐ LOTS OF SUGAR AS A CHILD
☐ EAR INFECTIONS
☐ 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

Family History

Family history - have any members of your family had:

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

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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: _____

_____

SLEEP

HOW MANY HOURS SLEEP DOES YOUR CHILD HAVE AT NIGHT? _____
WHAT TIME DOES HE/SHE GO TO BED? _____ WAKE UP? _____
DOES HE/SHE HAVE ISSUES SETTLING TO SLEEP? _____
DOES HE/SHE HAVE ISSUES WITH WAKING THROUGH THE NIGHT? _____
DO YOU CO SLEEP WITH YOUR CHILD OFTEN? _____

Exercise – Does your child participate in activities outside of school?

ACTIVITY	TYPE	HOW OFTEN EACH WEEK

Environmental or Other Exposures and Detox Assessment

ADVERSE REACTION TO:

☐ MONOSODIUM GLUTAMATE (MSG)
☐ ASPARTAME (NUTRASWEET)
☐ BANANAS ☐ GARLIC ☐ ONION ☐ CHEESE
☐ CITRUS FOODS ☐ CHOCOLATE
☐ SULPHITE CONTAINING FOODS
(DRIED FRUIT, SALAD BARS)
☐ PRESERVATIVES (SODIUM BENZOATE)
☐ OTHER _____

CHEMICAL NAME/DATE/LENGTH OF EXPOSURE
_____
_____
_____

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 _____

☐ DRY CLEAN YOUR CLOTHES FREQUENTLY
☐ LIVED IN A DAMP OR MOULDY
ENVIRONMENT OR HAD OTHER MOULD EXPOSURE
☐ DO YOU HAVE ANY PETS OR FARM ANIMALS

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_____

☐ ELECTROMAGNETIC RADIATION
☐ WORK WITH OIL BASED PAINT - ARTIST OR PAINTER

HOME ENVIRONMENT, ARE YOU EXPOSED TO:
☐ CHEMICALS
☐ MOULD

How did you find out about ITH? Friend or Family ☐ Website ☐ Search Engine ☐
Media ☐ Phone Book ☐
Other Health Professional ☐ Other: _____

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
☐ Nurse Consult
☐ Acupuncture
☐ Kinesiology
☐ Nutrition
☐ Bach Flowers
☐ Biomedical Consult
☐ Traditional Chinese Medicine
☐ Osteopathy
☐ Psychology
☐ Naturopathy
☐ 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
- ☐ COLD SORES
- ☐ HIVES
- ☐ 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 TEX

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

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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

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Nutrition and Diet

NUTRITION HISTORY

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

WAS/IS THIS CHILD BREASTFED? ☐ YES ☐ NO
FOR HOW LONG? _____

DID YOU USE FORMULA? ☐ YES ☐ NO

IF SO WHAT TYPE? _____

DID YOU HAVE TO CHANGE FORMULAS TO GET THE RIGHT ONE? IF SO PLEASE GIVE DETAILS:
_____

_____

DOES YOUR CHILD FOLLOW ANY SPECIAL DIET? ☐ YES ☐ NO

DESCRIBE: _____ _____

DOES THE WHOLE FAMILY FOLLOW THIS WAY OF EATING? ☐ YES ☐ NO

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILDS DIET? ☐ YES ☐ NO

PLEASE EXPLAIN YOUR CONCERNS (IF APPLICABLE):
_____

_____

HOW OFTEN DOES YOUR CHILD HAVE A BOWEL MOVEMENT? (IF KNOWN)_____
IS YOUR CHILD'S DIET HIGH IN JUNK FOOD AND/OR TAKE-AWAY? ☐ YES ☐ NO
DO YOU READ FOOD LABELS? ☐ YES ☐ NO _____
DO YOU COOK? ☐ YES ☐ NO, IF NO WHO DOES THE COOKING? _____
HOW MUCH WATER DOES YOUR CHILD DRINK EVERY DAY? _____
CHECK ALL THE FACTORS THAT APPLY TO YOUR CURRENT LIFESTYLE AND EATING HABITS:

☐ FAST EATER
☐ LATE NIGHT EATING
☐ NON AVAILABILITY OF HEALTHY FOODS
☐ EAT TOO MUCH UNDER STRESS
☐ EAT TOO LITTLE UNDER STRESS
☐ RELIANCE ON CONVENIENCE ITEMS
☐ FAMILY MEMBERS DON'T LIKE HEALTHY FOODS
☐ FAMILY MEMBERS HAVE SPECIAL DIETARY NEEDS OR FOOD PREFERENCES
☐ LOVE TO EAT
☐ ONLY EATS BECAUSE HE/SHE HAS TO
☐ HAS A NEGATIVE RELATIONSHIP WITH FOOD
☐ STRUGGLE WITH EATING ISSUES
☐ EMOTIONAL EATER (EAT WHEN SAD, LONELY, DEPRESSED)
☐ EAT IN THE MIDDLE OF THE NIGHT
☐ ERRACTIC EATING PATTERNS
☐ DISLIKE HEALTHY FOOD
☐ EAT TOO MUCH
☐ TIME CONSTRAINTS
☐ POOR SNACK CHOICES

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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: