



## Invitation to Health

256 Henry Parry Drive  
Wyoming NSW 2250 Ph: 4322 0700

# Intake Form - ADULT

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!

<b>Patient Information</b> Title (please circle): Mr. Mrs. Miss Ms. Master Dr Other ...		
Name:		Date:
Age:	DOB:	Gender:
Occupation:		
Address Details:		
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 <input type="checkbox"/> No <input type="checkbox"/>		
<b>Emergency Contact Name:</b>		Relationship:
<b>Emergency Contact Phone Number:</b>		
<b>Next of Kin:</b>		Relationship
<b>Next of Kin Contact Phone Number:</b>		
<b>Medicare Number:</b>	<b>Position Number:</b>	<b>Medicare Expiry Date:</b>
DVA Gold/White Number:	DVA Expiry Date:	
Pension/Health Care Card Number:	Card Expiry Date:	Pensioner: Yes / No
Preferred Method of contact for preventative care & early case detection reminders (e.g. immunizations, annual health checks, skin checks and pap smears):		
SMS to Mobile Phone: <input type="checkbox"/> Message left on answering machine <input type="checkbox"/> In writing <input type="checkbox"/>		
Preferred Method of contact to confirm appointments:		
SMS to Mobile phone: <input type="checkbox"/> Message left on answering machine: <input type="checkbox"/>		
<b>TO HELP THE PRACTICE PROVIDE APPROPRIATE HEALTH CARE, ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?</b>		
<input type="checkbox"/> ABORIGINAL <input type="checkbox"/> NEITHER ABORIGINAL OR TORRES STRAIT ISLANDER		
<input type="checkbox"/> TORRES STRAIT ISLANDER <input type="checkbox"/> BOTH ABORIGINAL AND TORRES STRAIT ISLANDER		
<b>PATIENT CONSENT (Circle if applicable only)</b>		
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: _____		
<b>How did you find out about Invitation to Health?</b>		
<input type="checkbox"/> Invitation to Health Facebook Page <input type="checkbox"/> Google/other search engine <input type="checkbox"/> Magazine/Newspaper		
<input type="checkbox"/> Our Email/Newsletter Communication <input type="checkbox"/> Our Website <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Practitioner referral		

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

- |  |   |
|--|---|
| <input type="checkbox"/> GP Consult                | <input type="checkbox"/> Biomedical Consult           |
| <input type="checkbox"/> Integrative Health Clinic | <input type="checkbox"/> Traditional Chinese Medicine |
| <input type="checkbox"/> Acupuncture               | <input type="checkbox"/> Osteopathy                   |
| <input type="checkbox"/> Kinesiology               | <input type="checkbox"/> Psychology                   |
| <input type="checkbox"/> Nutrition                 | <input type="checkbox"/> Naturopathy                  |
| <input type="checkbox"/> Dentist                   | <input type="checkbox"/> Neuro Feedback               |
| <input type="checkbox"/> Exercise Physiology       | <input type="checkbox"/> Other                        |

**What brings you to Invitation to Health?**


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


**List Medications:**

<b>MEDICATION INCLUDING Non-Prescribed Plus Dose</b> <i>e.g. Coversyl 10mg once a day</i>	<b>VITAMIN &amp; MINERAL SUPPLEMENTS</b>

**Allergies – NOT Intolerances**

**Prolonged or Regular Use of:**

	<input type="checkbox"/> OVER THE COUNTER MEDICATIONS
	<input type="checkbox"/> ACID BLOCKING DRUGS (Losec, Nexium, Pariet)
	<input type="checkbox"/> STERIODS (Prednisone, Inhalers) in the past
	<input type="checkbox"/> ANTIBIOTICS
	<input type="checkbox"/> ANTIDEPRESSANTS

**Preventative/Diagnostic Testing: this is vague, suggest saying: please tick if you have done this in the past 1-2 years, or provide the date if you know it.**

<input type="checkbox"/> SKIN CHECK	<input type="checkbox"/> VACCINATION
<input type="checkbox"/> BONE DENSITY	<input type="checkbox"/> COLONOSCOPY
<input type="checkbox"/> HEMOCCULT STOOL TEST FOR BLOOD	

**For Women for this would suggest asking an approximate date: please tick if you have done this in the past 1-2 years, write the approximate date if you know it.**

<input type="checkbox"/> PAP SMEAR	
<input type="checkbox"/> MAMMOGRAM	
<b>* BRING ALL SUPPLEMENTS/MEDICATIONS WITH YOU TO YOUR FIRST APPOINTMENT*</b>	

### 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	CARDIOVASCULAR	METABOLIC
<input type="checkbox"/> IRRITABLE BOWEL SYNDROME	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> INSULIN RESISTANCE
<input type="checkbox"/> INFLAMMATORY BOWEL DISEASE	<input type="checkbox"/> STROKE	<input type="checkbox"/> HYPOTHYROIDISM (LOW THYROID)
<input type="checkbox"/> PEPTIC ULCER	<input type="checkbox"/> ELEVATED CHOLESTEROL	<input type="checkbox"/> HYPERTHYROIDISM
<input type="checkbox"/> GORD (REFLUX)	<input type="checkbox"/> ARRHYTHMIA (IRREGULAR HEART RATE)	<input type="checkbox"/> POLYCYSTIC OVARIAN SYNDROME
<input type="checkbox"/> COELIAC DISEASE		<input type="checkbox"/> BULIMIA
<input type="checkbox"/> COLONOSCOPY	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ANOREXIA
WHEN	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> BINGE EATING DISORDER
<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER	<input type="checkbox"/> TYPE 1 DIABETES
		<input type="checkbox"/> TYPE 2 DIABETES
		<input type="checkbox"/> OTHER
CANCER	INFLAMMATORY/ AUTOIMMUNE	SKIN DISEASES
<input type="checkbox"/> LUNG CANCER	<input type="checkbox"/> CHRONIC FATIGUE SYNDROME	
<input type="checkbox"/> BREAST CANCER	<input type="checkbox"/> GLANDULAR FEVER	<input type="checkbox"/> ECZEMA
<input type="checkbox"/> COLON CANCER	<input type="checkbox"/> HASHIMOTO OR GRAVES	<input type="checkbox"/> PSORIASIS
<input type="checkbox"/> OVARIAN CANCER	<input type="checkbox"/> RHEUMATOID ARTHRITIS	<input type="checkbox"/> ACNE
<input type="checkbox"/> PROSTATE CANCER	<input type="checkbox"/> LUPUS/SLE	<input type="checkbox"/> MELANOMA
<input type="checkbox"/> SKIN CANCER	<input type="checkbox"/> IMMUNE DEFICIENCY DISEASE	<input type="checkbox"/> SKIN CANCER
<input type="checkbox"/> OTHER	<input type="checkbox"/> FOOD ALLERGIES	<input type="checkbox"/> OTHER
	<input type="checkbox"/> ENVIRONMENT ALLERGIES	
GENITAL AND URINARY	<input type="checkbox"/> MULTIPLE CHEMICAL SENSITIVITIES	NEUROLOGIC/MOOD
<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> LATEX ALLERGY	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> GOUT	<input type="checkbox"/> OTHER AUTOIMMUNE	<input type="checkbox"/> ANXIETY
<input type="checkbox"/> INTERSTITIAL CYSTITIS		<input type="checkbox"/> BIPOLAR DISORDER
<input type="checkbox"/> FREQUENT URINARY TRACT INFECTIONS	RESPIRATORY DISEASES	<input type="checkbox"/> SCHIZOPHRENIA
<input type="checkbox"/> FREQUENT YEAST INFECTIONS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEADACHES
<input type="checkbox"/> ERECTILE DYSFUNCTION	<input type="checkbox"/> CHRONIC SINUSITIS	<input type="checkbox"/> MIGRAINES
<input type="checkbox"/> SEXUAL DYSFUNCTION	<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> ADD/ADHD
	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> AUTISM
	<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> MILD COGNITIVE
MUSCULOSKELETAL OR PAIN	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> PARKINSON'S DISEASE
<input type="checkbox"/> OSTEOARTHRITIS	<input type="checkbox"/> SLEEP APNOEA	<input type="checkbox"/> MULTIPLE SCLEROSIS
<input type="checkbox"/> FIBROMYALGIA	<input type="checkbox"/> OTHER	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> CHRONIC PAIN		<input type="checkbox"/> OTHER
<input type="checkbox"/> OTHER	PREVIOUS ACCIDENTS OR OPERATIONS	<input type="checkbox"/> HEAD INJURIES- WHEN?
	<input type="checkbox"/>	
	<input type="checkbox"/>	

<b>Further Medical History</b>		
<b>YOUR CHILDHOOD HISTORY</b>	<b>FOR WOMEN <i>OBSTETRIC HISTORY</i></b>	<b>MENOPAUSE HISTORY</b>
<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> VAGINAL DELIVERIES	<input type="checkbox"/> HORMONE REPLACEMENT THERAPY
	<input type="checkbox"/> MISCARRIAGE	
<input type="checkbox"/> RECURRENT STREP THROAT	<input type="checkbox"/> ABORTION	<input type="checkbox"/> CURRENTLY?
<input type="checkbox"/> STOMACH ACHES	<input type="checkbox"/> LIVING CHILDREN	<input type="checkbox"/> YEARS?
<input type="checkbox"/> OTHER CHILDHOOD ILLNESSES	<input type="checkbox"/> POST PARTUM DEPRESSION	<input type="checkbox"/> PAST?
	<input type="checkbox"/> PRE-ECLAMPSIA	WHEN?
<b>DENTAL HISTORY</b>	<input type="checkbox"/> GESTATIONAL DIABETES	
<input type="checkbox"/> SILVER MERCURY FILLINGS	<input type="checkbox"/> BREAST FEEDING	<b>LIFESTYLE AND SELF-CARE</b>
HOW MANY	HOW LONG?	
<input type="checkbox"/> GOLD FILLINGS	<input type="checkbox"/> ORAL CONTRACEPTIVE PILL AT ANY TIME?	<input type="checkbox"/> Ex-Smoker
<input type="checkbox"/> ROOT CANALS		<input type="checkbox"/> CURRENTLY SMOKING: how many per day
<input type="checkbox"/> IMPLANTS	WHEN? HOW LONG FOR	
<input type="checkbox"/> TOOTH OR JAW PAIN	<input type="checkbox"/> C-SECTION	<b>SLEEP PATTERNS</b>
<input type="checkbox"/> BLEEDING GUMS		<input type="checkbox"/> HOURS SLEEP EACH NIGHT
<input type="checkbox"/> GINGIVITIS		<input type="checkbox"/> DO YOU WAKE OFTEN
		<input type="checkbox"/> DIFFICULTY GETTING TO SLEEP

<b>Current Symptoms – Please tick if you have any of the following symptoms:</b>		
<b>SKIN PROBLEMS</b>	<b>HEAD, EYES &amp; EARS</b>	<b>CARDIOVASCULAR</b>
<input type="checkbox"/> ACNE	<input type="checkbox"/> DISTORTED SMELL	<input type="checkbox"/> CHEST PAIN
<input type="checkbox"/> ATHLETE'S FOOT	<input type="checkbox"/> DISTORTED TASTE	<input type="checkbox"/> BREATHLESSNESS
<input type="checkbox"/> BUMPS BACK OF ARM	<input type="checkbox"/> BAD BREATH	<input type="checkbox"/> PALPITATIONS
<input type="checkbox"/> CELLULITE	<input type="checkbox"/> EAR FULLNESS	<input type="checkbox"/> PAIN IN CALVES
<input type="checkbox"/> DANDRUFF	<input type="checkbox"/> EAR PAIN	<input type="checkbox"/> SWOLLEN ANKLES
<input type="checkbox"/> DARK CIRCLES UNDER EYES	<input type="checkbox"/> EAR RINGING	<input type="checkbox"/> VARICOSE VEINS
<input type="checkbox"/> EARS GET RED	<input type="checkbox"/> HEARING PROBLEMS	<input type="checkbox"/> LIGHT HEADEDNESS
	<input type="checkbox"/> RECURRENT SORE THROAT	<input type="checkbox"/> FAINTING
	<input type="checkbox"/> HOARSENESS	<b>RESPIRATORY</b>
<input type="checkbox"/> EASY BRUISING	<input type="checkbox"/> EYE PAIN/IRRITATION	<input type="checkbox"/> SNORING
<input type="checkbox"/> ECZEMA	<input type="checkbox"/> VISION DISTURBANCE	<input type="checkbox"/> COUGH
<input type="checkbox"/> HERPES – GENITAL	<input type="checkbox"/> SINUS	<input type="checkbox"/> COUGHING UP BLOOD
<input type="checkbox"/> COLD SORES	<input type="checkbox"/> MIGRAINE	<input type="checkbox"/> HAYFEVER
<input type="checkbox"/> HIVES	<input type="checkbox"/> HEADACHE	<input type="checkbox"/> SINUS FULLNESS
<input type="checkbox"/> JOCK ITCH	<input type="checkbox"/> NOISE SENSITIVE	<input type="checkbox"/> NASAL STUFFINESS
<input type="checkbox"/> CHANGE IN MOLES	<input type="checkbox"/> JAW PAIN	<input type="checkbox"/> NOSE BLEEDS
	<input type="checkbox"/> ITCHY EARS	<input type="checkbox"/> BREATHE THRU MOUTH

<b>Current Symptoms continued...</b>		
<b>Skin problems continued...</b>	<b>NAILS</b>	<b>Respiratory continued ...</b>
<input type="checkbox"/> OILY SKIN	<input type="checkbox"/> BITTEN	<input type="checkbox"/> POST NASAL DRIP
<input type="checkbox"/> RASH	<input type="checkbox"/> BRITTLE	<input type="checkbox"/> SHORTNESS OF BREATH
<input type="checkbox"/> SENSITIVE TO BITES	<input type="checkbox"/> FUNGUS	<input type="checkbox"/> AT REST
<input type="checkbox"/> SHINGLES	<input type="checkbox"/> RIDGES	<input type="checkbox"/> WITH EXERCISE
<input type="checkbox"/> SKIN ITCHING	<input type="checkbox"/> THICKENED	
<input type="checkbox"/> SKIN DRYNESS	<input type="checkbox"/> WHITE SPOTS/LINES	<b>ENDOCRINE/IMMUNE</b>
<input type="checkbox"/> STRONG BODY ODOUR		<input type="checkbox"/> COLD HANDS/FEET
ITCHY ANUS OR VAGINA		<input type="checkbox"/> COLD/HEAT INTOLERANCE
<b>DIGESTION</b>		<input type="checkbox"/> FATIGUE
<input type="checkbox"/> BLOATING AFTER EATING	<b>MUSCLE/BONE</b>	<input type="checkbox"/> WEIGHT GAIN
<input type="checkbox"/> BLOOD IN STOOLS	<input type="checkbox"/> MUSCLE TWITCHING	<input type="checkbox"/> GET SICK A LOT
<input type="checkbox"/> BURPING	<input type="checkbox"/> MUSCLE PAIN	<input type="checkbox"/> SWOLLEN LYMPH NODES
<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> JOINT PAN OR SWELLING	<input type="checkbox"/> HAIR LOSS
<input type="checkbox"/> ANAL ITCHING	<input type="checkbox"/> JOINT STIFFNESS	
<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> BACK PAIN	<b>URINARY</b>
<input type="checkbox"/> DIFFICULTY SWALLOWING/PAINFUL		<input type="checkbox"/> HESITANCY
<input type="checkbox"/> DRY MOUTH	<b>MOOD NERVES</b>	<input type="checkbox"/> FREQUENT UTI
<input type="checkbox"/> FISSURES	<input type="checkbox"/> DIFFICULTY CONCENTRATING	<input type="checkbox"/> PAIN/BURNING
<input type="checkbox"/> HEARTBURN (REFLUX)	<input type="checkbox"/> DIFFICULT WITH BALANCE	<input type="checkbox"/> URGENCY
<input type="checkbox"/> HAEMORRHOIDS	<input type="checkbox"/> DIFFICULTY WITH JUDGEMENT	<input type="checkbox"/> LEAKING
<b>INTOLERANCE TO:</b>	<input type="checkbox"/> DIFFICULTY WITH MEMORY	<input type="checkbox"/> BLOOD IN URINE
<input type="checkbox"/> LACTOSE	<input type="checkbox"/> DIZZINESS (SPINNING)	<input type="checkbox"/> FREQUENT URINATION
<input type="checkbox"/> ALL MILK PRODUCTS	<input type="checkbox"/> SUICIDAL THOUGHTS	
<input type="checkbox"/> GLUTEN	<input type="checkbox"/> DEPRESSION	
<input type="checkbox"/> CORN	<input type="checkbox"/> NUMBNESS	
<input type="checkbox"/> EGGS	<input type="checkbox"/> PANIC ATTACKS	
<input type="checkbox"/> FATTY FOODS	<input type="checkbox"/> ANXIETY	
<input type="checkbox"/> OTHER	<input type="checkbox"/> PHOBIAS/FEARS	
<b>DIGESTION</b>	<input type="checkbox"/> PARANOIA	
<input type="checkbox"/> YELLOW EYES/SKIN	<input type="checkbox"/> HELLUCINATIONS	<b>MALE REPRODUCTIVE</b>
<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> DISCHARGE FROM PENIS
<input type="checkbox"/> MUCOUS IN STOOLS	<input type="checkbox"/> TREMOR	<input type="checkbox"/> EJACULATION PROBLEM
<input type="checkbox"/> NAUSEA	<input type="checkbox"/> SLEEPNG PROBLEMS	<input type="checkbox"/> GENITAL PAIN
<input type="checkbox"/> STRONG STOOL ODOR	<input type="checkbox"/> MOTION OR CAR SICKNESS	<input type="checkbox"/> POOR LIBIDO (LOW SEX DRIVE)
<input type="checkbox"/> UNDIGESTED FOODS IN STOOLS	<input type="checkbox"/> FEELING 'OUT OF BODY'	<input type="checkbox"/> IMPOTENCE
<input type="checkbox"/> VOMITING		<input type="checkbox"/> LUMPS IN TESTICLES
<input type="checkbox"/> UNINTENTIONAL WEIGHT GAIN		
<input type="checkbox"/> FLOATING OR LIGHT-COLOURED STOOL		

FEMALE REPRODUCTIVE	PREMENSTRUAL	MENOPAUSE- WHAT AGE:
<input type="checkbox"/> BREAST CYSTS	<input type="checkbox"/> BREAST TENDERNESS	<input type="checkbox"/> HOT FLUSHES
<input type="checkbox"/> BREAST TENDERNESS	<input type="checkbox"/> MOODS SWINGS	<input type="checkbox"/> VAGINAL DRYNESS
<input type="checkbox"/> OVARIAN CYST	<input type="checkbox"/> FOOD CRAVING	<input type="checkbox"/> PAINFUL SEX
<input type="checkbox"/> POOR LIBIDO (SEX DRIVE)	<input type="checkbox"/> SLEEP CHANGE	<input type="checkbox"/> DECREASED LIBIDO
<input type="checkbox"/> PELVIC PAIN	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> WEIGHT GAIN
<input type="checkbox"/> INFERTILITY	<input type="checkbox"/> IRRITABILITY	<input type="checkbox"/> SLEEP DISTURBANCE
<input type="checkbox"/> VAGINAL DISCHARGE	<b>MENSTRUAL</b>	<input type="checkbox"/> MOOD DISTURBANCE
<input type="checkbox"/> VAGINAL ITCH	<input type="checkbox"/> CRAMPS	
<input type="checkbox"/> BLEEDING BETWEEN PERIODS	<input type="checkbox"/> HEAVY PERIODS	
<input type="checkbox"/> PAINFUL SEXUAL INTERCOURSE	<input type="checkbox"/> IRREGULAR PERIODS/SPOTTING	
	<input type="checkbox"/> NO PERIODS	
	<input type="checkbox"/> CHANGE IN BOWEL HABIT WITH MENSES	

## Nutrition and Diet History

Have you made any changes in your eating habits because of your Health  YES  NO.

Describe:

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**CHECK ALL THAT APPLY PARTIALLY OR FULLY TO YOU:**

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

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

<input type="checkbox"/> FAST EATER	<input type="checkbox"/> ERRACTIC EATING PATTERNS	<input type="checkbox"/> EAT TOO MUCH
<input type="checkbox"/> LATE NIGHT EATING	<input type="checkbox"/> TRAVEL FREQUENTLY	<input type="checkbox"/> EAT BECAUSE I HAVE TO
<input type="checkbox"/> EAT TOO LITTLE UNDER STRESS	<input type="checkbox"/> LOVE TO EAT	<input type="checkbox"/> EAT IN THE MIDDLE OF THE NIGHT
<input type="checkbox"/> EAT TOO MUCH UNDER STRESS	<input type="checkbox"/> HAVE A NEGATIVE RELATIONSHIP WITH FOOD	<input type="checkbox"/> RELIANCE ON CONVENIENCE ITEMS
<input type="checkbox"/> DO YOU COOK	<input type="checkbox"/> DO YOU ADD SALT TO FOOD	

**STRESS/COPING** Check all that apply:

I AM SEEING/HAVE SEEN A PSYCHOLOGIST OR COUNSELLOR

I HAVE AN EXCESSIVE AMOUNT OR STRESS

**DAILY STRESSORS: RATE ON CALE OF 1-10 (10 IS WORST)**

WORK

FAMILY

SOCIAL

FINANCES

HEALTH

OTHER

**I PRACTICE MEDITATION OR RELAXATION TECHNIQUE. HOW OFTEN?**

Check all that apply:

YOGA

MEDITATION

IMAGERY

BREATHING

TAI CHI

PRAYER

ORGANISED EXERCISE

WALKING

OTHER

**Readiness to Change**

RATE ON A SCALE OF: 5 being (very willing) and 1 (not willing)

**In Order to improve your Health. How willing are you to?**

Significantly modify your diet?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>
Keep a record of everything you eat each day?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>
Modify your lifestyle?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>
Engage in Regular Exercise?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>
Take several Nutritional supplements each day?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>
Practice a relaxation technique?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>
How confident are you of your ability to organise and follow through on the above health related activities?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/>

Exercise - Current Exercise Program			
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 including exercise in your life? <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High list problems that limit activity: _____			
Do you feel unusually fatigued after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please describe: _____			
Do you usually sweat when exercising? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Environmental or Other Exposures and Detox Assessment	
ADVERSE REACTION TO	HISTORY OF:
<input type="checkbox"/> CAFFEINE	<input type="checkbox"/> JAUNDICE (TURNING YELLOW)
<input type="checkbox"/> IRRITABLE WIRED ACHES & PAINS	<input type="checkbox"/> GILBERT'S SYNDROME OR A LIVER DISORDER
<input type="checkbox"/> MONOSODIUM GLUTAMATE (MSG)	<b>EXPLAIN</b>
<input type="checkbox"/> ASPARTAME (NUTRASWEET)	
<input type="checkbox"/> BANANAS GARLIC ONION CHEESE	<b>EXPOSURE TO HARMFUL CHEMICALS SUCH AS:</b>
<input type="checkbox"/> CITRUS FOODS CHOCOLATE ALCOHOL RED WINE	<input type="checkbox"/> HERBICIDES
<input type="checkbox"/> SULPHITE CONTAINING FOODS	<input type="checkbox"/> INSECTICIDES (FREQUENT VISITS OF EXTERMINATOR)
<input type="checkbox"/> (WINE, DRIED FRUIT, SALAD BARS)	<input type="checkbox"/> PESTICIDES
<input type="checkbox"/> PRESERVATIVES (SODIUM BENZOATE)	<input type="checkbox"/> ORGANIC SOLVENTS
<input type="checkbox"/> OTHER	<input type="checkbox"/> HEAVY METALS
	<input type="checkbox"/> OTHER
<b>YOU ARE AFFECTED BY</b>	
	<input type="checkbox"/> CHEMICAL NAME/DATE/LENGTH OF EXPOSURE
<input type="checkbox"/> CIGARETTE SMOKE	
<input type="checkbox"/> PERFUMES/COLOGNES	
<input type="checkbox"/> AUTO EXHAUST FUMES	<input type="checkbox"/> DRY CLEAN YOUR CLOTHES FREQUENTLY
<input type="checkbox"/> OTHER	<input type="checkbox"/> LIVED OR WORKED IN A DAMP OR MOULDY ENVIRONMENT OR HAD OTHER MOULD EXPOSURE
	<input type="checkbox"/> DO YOU HAVE ANY PETS OR FARM ANIMALS
<b>IN YOUR WORK OR HOME ENVIRONMENT ARE YOU</b>	<input type="checkbox"/> ELECTROMAGNETIC RADIATION
<b>EXPOSED TO:</b>	<input type="checkbox"/> WORK WITH OIL BASED PAINT - ARTIST OR PAINTER
<input type="checkbox"/> CHEMICALS	<input type="checkbox"/> HISTORY OF DRINKING PROBLEM
<input type="checkbox"/> MOULD	SEE LIFESTYLESECTION FOR DETAILED QUESTIONS



**NUTRITION AND DIET**

**HOW OFTEN DO YOU WEIGH YOURSELF?**

DAILY  WEEKLY  MONTHLY  RARELY  NEVER

**DO YOU AVOID ANY PARTICULAR FOODS?**  YES  NO

IF YES, TYPE THE 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

**Please list below the times you have the following meals, and what you would normally have for each meal**

MEAL	TIME	WHAT WOULD YOU NORMALLY EAT
Breakfast		
Morning Tea		
Lunch		
Afternoon Tea		
Dinner		
After Dinner		

**What would you have for general snacks?**

**What types of food do you crave?**

**Are you frequently hungry?**

**Can you leave 3 to 4 hours between meals without needing to snack? (Not including overnight)**

YES  NO

**\* PLEASE REMEMBER BRING ALL SUPPLEMENTS/MEDICATIONS WITH YOU TO YOUR FIRST APPOINTMENT\***

# APPOINTMENT CONFIRMATION & CANCELLATION POLICIES DEEP HEALTH PROGRAMME

Effective from the 1st December, 2018

Invitation to Health advises we have implemented new policies for Appointment Reminders and Confirmation of Appointments to maximise doctor availability for our patients.

At the time of booking your initial Invitation to Deep Health appointment, your credit card details will be taken and the amount of the first consultation fee held against your card for a period of 10-15 days (depending on your card provider) as a guarantee for your scheduled appointment. At the end of this period, the funds shall be released back to you until the day of your appointment, and your card information will be held and utilised in the event of cancellation or non-arrival fees.

## APPOINTMENT CANCELLATION POLICY

All appointment cancellations are required to be made a **minimum of 5 BUSINESS DAYS** prior to your appointment to avoid the **full consultation fee**. ie: If your appointment is scheduled on a Monday, notice to cancel is required by 5pm Monday of the week prior. This includes "No Shows". **The full consult fee will be debited from the credit card stored** and no future appointments shall be made until the cancellation fee has been paid.

## SMS REMINDER POLICY

**10 days** – A reminder text message will be sent to you 10 days prior to your appointment. Please reply to confirm your appointment or call Reception to reschedule. **Failure to reply prior to 2 BUSINESS DAYS in advance of your appointment will result in your appointment being cancelled** and offered to patients on our waiting list. **The full consult fee will be debited from the credit card stored**

**24 Hours** – A second reminder SMS will be sent 24 hours prior to your appointment as a reminder (no response required).

All patients without mobile phones will be contacted at the same intervals on their landline.

Please sign to acknowledge the above policies.

Signature:

\_\_\_\_\_ Date: \_\_\_\_\_