



NEW PATIENT FORM

Personal Details

Title	Given Name	Surname
Home Address		
Address (continued)		Postcode
Mobile Phone	Other Phone	
Email		
Age	Date of Birth	Occupation
Private health insurance fund Or <input type="checkbox"/> None		

Emergency Contact

Contact Name
Contact Phone
Relationship to Me

My General Practitioner

GP's Name
GP's Location
May we contact your GP about your treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No

I heard about you from:

Please tick any that apply:

- | | |
|---|---|
| <input type="checkbox"/> Someone who is a patient | <input type="checkbox"/> Invitation to Health newsletter or email |
| <input type="checkbox"/> A practitioner who referred me | <input type="checkbox"/> Invitation to Health website |
| <input type="checkbox"/> A friend or family member | <input type="checkbox"/> Sage Acupuncture website |
| <input type="checkbox"/> Google or other search engine | <input type="checkbox"/> Magazine or newspaper |
| <input type="checkbox"/> hotdoc | |
| <input type="checkbox"/> Somewhere else | |

Consent to Treatment

Welcome to Sage Acupuncture at Invitation To Health. The therapies we provide have a long history of safe practice, however there are always some risks associated with any sort of treatment. This practice may use Acupuncture and/or Chinese herbal medicine in your care.

Please tell your practitioner if you do not want a particular kind of therapy.

As with most therapies, there is a small risk of adverse reactions. With acupuncture, you may experience itchiness, pain, bruising, dizziness, numbness or an aggravation of your condition.

The best way to minimise risks is to answer all questions about your health completely and honestly. We will explain all treatments to you before we commence them but please ask if you require further explanation or have any questions or worries.

As your appointment time is specially reserved for you, a \$45 administration fee will apply for a cancellation of appointment with less than 48 hours' notice.

I understand the risks outlined above and agree to undergo treatment.

I understand that an anonymised treatment history may be shared with other Medical professionals. Patient identities always remain confidential and will never be shared.

Full Name	Today's Date
Signature	

Major Complaints

What are the major problems you would like to be treated today, and when did they occur?

What is the problem?	When did it start?
What is the problem?	When did it start?
What is the problem?	When did it start?

Current Treatment

Are you receiving any other treatments? Please provide details:

Or None

Expectations

What would you like to achieve from today's treatment?

Medications

What medications (both prescribed and over-the-counter) are you taking?

Medicine name (eg. Coversyl)	Dosage (eg. 10mg once a day)	Disorder (eg. high blood pressure)
Medicine	Dosage	Disorder
Medicine	Dosage	Disorder
Medicine	Dosage	Disorder

Vitamins and mineral supplements

Are you taking any vitamins or mineral supplements? Please provide details of brand and strength:

Or None

Prolonged or regular use

Please indicate if you regularly take or have taken any of these classes of drugs:

- over the counter medications
- acid blocking drugs (Losec, Nexium, Pariet)
- steroids (Prednisone, inhalers)
- antibiotics
- antidepressants
- medical cannabis

Anything else that is relevant

Family Medical History

Please indicate if anyone in your family has ever had any of these conditions:

- diabetes
- hepatitis
- stroke
- heart disease
- kidney disease
- cancer
- asthma
- epilepsy/seizures
- mental illness
- allergies

Anything else that is relevant

Preventative & diagnostic testing

Have you had any of these tests in the last 2 years:

- skin check
- bone density
- hemoccult stool test for blood
- vaccination
- colonoscopy

Special conditions

We need to take special care with acupuncture if certain special conditions apply:

- bruise easily
- bleeding disorder
- suffer from fainting, dizziness, or epilepsy
- currently pregnant
- have an infectious disease

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	

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

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	SKIN DISEASES
<input type="checkbox"/> COLON CANCER	<input type="checkbox"/> HASHIMOTO OR GRAVES	<input type="checkbox"/> ECZEMA
<input type="checkbox"/> OVARIAN CANCER	<input type="checkbox"/> RHEUMATOID ARTHRITIS	<input type="checkbox"/> PSORIASIS
<input type="checkbox"/> PROSTATE CANCER	<input type="checkbox"/> LUPUS/SLE	<input type="checkbox"/> ACNE
<input type="checkbox"/> SKIN CANCER	<input type="checkbox"/> IMMUNE DEFICIENCY DISEASE	<input type="checkbox"/> MELANOMA
<input type="checkbox"/> OTHER	<input type="checkbox"/> FOOD ALLERGIES	<input type="checkbox"/> SKIN CANCER
	<input type="checkbox"/> ENVIRONMENT ALLERGIES	<input type="checkbox"/> OTHER
GENITAL AND URINARY	<input type="checkbox"/> MULTIPLE CHEMICAL SENSITIVITIES	
<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> LATEX ALLERGY	NEUROLOGIC/MOOD
<input type="checkbox"/> GOUT	<input type="checkbox"/> OTHER AUTOIMMUNE	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> INTERSTITIAL CYSTITIS		<input type="checkbox"/> ANXIETY
<input type="checkbox"/> FREQUENT URINARY TRACT INFECTIONS	RESPIRATORY DISEASES	<input type="checkbox"/> BIPOLAR DISORDER
<input type="checkbox"/> FREQUENT YEAST INFECTIONS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> SCHIZOPHRENIA
<input type="checkbox"/> ERECTILE DYSFUNCTION	<input type="checkbox"/> CHRONIC SINUSITIS	<input type="checkbox"/> HEADACHES
<input type="checkbox"/> SEXUAL DYSFUNCTION	<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> MIGRAINES
	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> ADD/ADHD
	<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> AUTISM
MUSCULOSKELETAL OR PAIN	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> MILD COGNITIVE
<input type="checkbox"/> OSTEOARTHRITIS	<input type="checkbox"/> SLEEP APNOEA	<input type="checkbox"/> PARKINSON'S DISEASE
<input type="checkbox"/> FIBROMYALGIA	<input type="checkbox"/> OTHER	<input type="checkbox"/> MULTIPLE SCLEROSIS
<input type="checkbox"/> CHRONIC PAIN		<input type="checkbox"/> SEIZURES
<input type="checkbox"/> OTHER	PREVIOUS ACCIDENTS OR OPERATIONS	<input type="checkbox"/> OTHER
	<input type="checkbox"/>	<input type="checkbox"/> HEAD INJURIES- WHEN?
	<input type="checkbox"/>	

Further Medical History		
YOUR CHILDHOOD HISTORY	FOR WOMEN <i>OBSTETRIC HISTORY</i>	MENOPAUSE HISTORY
<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?
DENTAL HISTORY	<input type="checkbox"/> GESTATIONAL DIABETES	
<input type="checkbox"/> SILVER MERCURY FILLINGS	<input type="checkbox"/> BREAST FEEDING	LIFESTYLE AND SELF-CARE
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	SLEEP PATTERNS
<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

Current Symptoms – Please tick if you have any of the following symptoms:		
SKIN PROBLEMS	HEAD, EYES & EARS	CARDIOVASCULAR
<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	RESPIRATORY
<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	BREATHE THRU MOUTH

Current Symptoms continued...		
Skin problems continued...	NAILS	Respiratory continued ...
<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	ENDOCRINE/IMMUNE
<input type="checkbox"/> STRONG BODY ODOUR	<input type="checkbox"/>	<input type="checkbox"/> COLD HANDS/FEET
ITCHY ANUS OR VAGINA		<input type="checkbox"/> COLD/HEAT INTOLERANCE
DIGESTION		<input type="checkbox"/> FATIGUE
<input type="checkbox"/> BLOATING AFTER EATING	MUSCLE/BONE	<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	URINARY
<input type="checkbox"/> DIFFICULTY SWALLOWING/PAINFUL		<input type="checkbox"/> HESITANCY
<input type="checkbox"/> DRY MOUTH	MOOD NERVES	<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
INTOLERANCE TO:	<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	
DIGESTION	<input type="checkbox"/> PARANOIA	
<input type="checkbox"/> YELLOW EYES/SKIN	<input type="checkbox"/> HELLUCINATIONS	MALE REPRODUCTIVE
<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"/>	<input type="checkbox"/> LUMPS IN TESTICLES
<input type="checkbox"/> UNINTENTIONAL WEIGHT GAIN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> FLOATING OR LIGHT-COLOURED STOOL	<input type="checkbox"/>	<input type="checkbox"/>

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	MENSTRUAL	<input type="checkbox"/> MOOD DISTURBANCE
<input type="checkbox"/> VAGINAL ITCH	<input type="checkbox"/> CRAMPS	<input type="checkbox"/>
<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"/>
	<input type="checkbox"/> NO PERIODS	<input type="checkbox"/>
	<input type="checkbox"/> CHANGE IN BOWEL HABIT WITH MENSES	<input type="checkbox"/>

Nutrition and Diet History

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

Describe:

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

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	<input type="checkbox"/>

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
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Stretching: _____

Cardio/Aerobics: _____

Strength: _____

Other (Yoga, Pilates etc): _____

Sports or leisure activity: _____

Rate your level of motivation for including 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	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)	EXPLAIN
<input type="checkbox"/> ASPARTAME (NUTRASWEET)	
<input type="checkbox"/> BANANAS GARLIC ONION CHEESE	EXPOSURE TO HARMFUL CHEMICALS SUCH AS:
<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
YOU ARE AFFECTED BY	
	<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
IN YOUR WORK OR HOME ENVIRONMENT ARE YOU EXPOSED TO:	<input type="checkbox"/> ELECTROMAGNETIC RADIATION
<input type="checkbox"/> CHEMICALS	<input type="checkbox"/> WORK WITH OIL BASED PAINT - ARTIST OR PAINTER
<input type="checkbox"/> MOULD	<input type="checkbox"/> HISTORY OF DRINKING PROBLEM
	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 NORMALL EAT
Breakfast		
Morning Tea		
Lunch		
Afternoon Tea		
Dinner		
After Dinner		

What would you have for general snacks?

What types of food to 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***