Naturopathic health care

# Initial consultation questionnaire – part a – Personal details

Date of Consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Fund: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Health Care Providers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Occupations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Initial consultation questionnaire – part b – Current concerns and medications

What is the main reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other symptoms, signs or concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medically diagnosed conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you discovered any self-diagnosed conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any prescription medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - Please list all of these here:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Strength (mg)** | **Dosage (per day)** | **Treating?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Do you take any nutritional supplements, herbal medicines or elixirs? \_\_\_\_\_\_\_\_\_\_\_\_\_ Please list these on PART C

# Initial consultation questionnaire – part D – Consent

Do you **consent** to providing your medical and health information to this Naturopath and having noninvasive diagnostic tests performed during this session (i.e. Blood pressure, tongue and nail analysis and Iridology? \_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Initial consultation questionnaire – part E – medical history & body system review

Please List Any of the of the following that you feel comfortable sharing:

|  |  |
| --- | --- |
| Operations / Surgeries |  |
| Previous illnesses |  |
| Major Viruses / Infections |  |
| Traumas Physical / Emotional |  |
| Hospitalizations |  |
| Accidents or Injuries |  |
| Chemical exposure at Home / Work |  |
| Any Inheritable / Genetic conditions |  |

**Are you experiencing any of these symptoms? (Please circle each relevant symptom):**

Nausea Vomiting Heart Burn Bloating Constipation Belching Abdominal Pain

Gas Diarrhea Changed bowel movements Changed urination frequency Rectal bleeding

Headaches Fainting Eyesight disturbances Mood Disturbance Hearing loss

Loss of sense of smell Coughing Wheezing Snoring Itching Skin irritation

Seizures Numbness Weakness or Tingling in limbs Loss of Consciousness Palpitations

Menstruation: Cramps Pain Missed periods Irregularity Headaches PMS PMT

# Initial consultation questionnaire – part f – diet and nutrition

Do you follow any particular diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food Intolerances/ Sensitivities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any food groups that you avoid? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you avoid any specific foods or drinks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have fairly, regular meal times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which foods or drinks do you experience cravings for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of foods do you find yourself reaching for most often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you skip meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water would you drink in 24 hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you add salt to your cooking or meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**24hour Diet (Food Intake) Recall:**

|  |  |
| --- | --- |
| Breakfast |  |
| Lunch |  |
| Dinner |  |
| Snacks |  |
| Fluids/Drinks/Beverages |  |

**How often do you consume the following? (Please Circle):**

Vegetables Daily Most days Some days Rarely Never

Fruit/ Berries Daily Most days Some days Rarely Never

Nuts/ Seeds Daily Most days Some days Rarely Never

Legumes/Peas/Beans Daily Most days Some days Rarely Never

Eggs Daily Most days Some days Rarely Never

Fish Daily Most days Some days Rarely Never

Meat Daily Most days Some days Rarely Never

Sweets & Treats Daily Most days Some days Rarely Never

Take away food Daily Most days Some days Rarely Never

Coffee/Tea Daily Most days Some days Rarely Never

Soft Drinks/Energy Drinks Daily Most days Some days Rarely Never

# Initial consultation questionnaire – part g – current health status

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Are you content with your current weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an ideal weight goal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_\_\_\_\_\_ If so how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_ Daily Weekly Once a month Occasionally

Do you use any stress management techniques? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you engaged in a sport, gym or exercise routine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please rate your current health status by circling the relevant scale number:**

Happiness 1 2 3 4 5 6 7 8 9 Excellent

Confidence 1 2 3 4 5 6 7 8 9 Excellent

Health 1 2 3 4 5 6 7 8 9 Excellent

Vitality/Energy 1 2 3 4 5 6 7 8 9 Excellent

Fitness 1 2 3 4 5 6 7 8 9 Excellent

Activity level 1 2 3 4 5 6 7 8 9 Intense

Stress 1 2 3 4 5 6 7 8 9 Intense

Daily work load 1 2 3 4 5 6 7 8 9 Intense

Focus/Concentration 1 2 3 4 5 6 7 8 9 Excellent

Daytime Fatigue 1 2 3 4 5 6 7 8 9 Intense

Pain 1 2 3 4 5 6 7 8 9 Intense

Allergy symptoms 1 2 3 4 5 6 7 8 9 Intense

Recovery after illness 1 2 3 4 5 6 7 8 9 Excellent

Recovery after injury 1 2 3 4 5 6 7 8 9 Excellent

Family/ Social Support 1 2 3 4 5 6 7 8 9 Excellent

Sleep pattern 1 2 3 4 5 6 7 8 9 Excellent

Thank you for answering all of these questions and at your next consultation we can compare scores to assess how your personalized Naturopathic prescription is benefitting you. 😊