The Biology of Joy

Clinic Consult Form — Initial Consultation

CONFIDENTIAL *(Please print the complete document, complete pages 1-5 / sections 1-6 and bring with to your consultation)*

1. CLIENT INFORMATION

Consultation date: / /	Consultation time: am/pm
Title: Given name:	Surname:
Preferred name:	Address:
Post code:	Occupation:
Phone:	Date of birth:
Emergency contact:	Phone:
General practitioner name:	Phone:
Address:	

2. PRESENTING COMPLAINTS

Commencement of presenting complaints:

3. FAMILY HISTORY

Mother: Father:

Other:

4. PERSONAL MEDICAL HISTORY

Country of birth: Infanthood (Include vaccination reactions):

Childhood illnesses:

Adolescence:

Adulthood:

Surgery:

Traumatic events affecting health?

Recently travelled overseas?

5. LIFESTYLE

Coffee/tea/soft drinks/energy drinks:

Sugar:

Alcohol:

Other recreational drugs:

Exercise:

Hobbies:

Stressors:

How stress is handled:

Energy levels:

Amalgam fillings:

Best time of the day:

Worst time of the day:

Does weather affect client?

Symptoms of a cyclical nature:

No. hours in front of TV and computer:

Use of mobile (estimated amount of time/day):

Smoking?

Last visit to medical doctor: Reason:

Last visit to Natural Health Practitioner: Reason:

Current medications (List):

Previous medications (List):

ANATOMICAL SYSTEMS	SYMPTOMS AND SIGNS AND RESPONSE FROM CLIENT
(i) IMMUNE SYSTEM	Do you experience frequent colds, flus, infections? Any diagnosed autoimmune conditions? Lymph nodes – sore, swollen, infected?
(ii) NERVOUS SYSTEM/SLEEP	How many hours sleep do you get a night? Do you wake refreshed? Difficulty staying asleep? Difficulty falling asleep? Do you experience headaches/migraines?
(iii) URINARY TRACT	Difficulty in passing urine? Frequent or painful urination? Dark, pale, cloudy urine? History of urinary tract infections/cystitis?
(iv) GASTROINTESTINAL TRACT	Poor appetite/ excessive appetite? Do you ever experience gas or bloating? Heartburn/indigestion/ reflux? Dry stools or constipation? Loose stools or diarrhoea? Blood/mucous in stool? Any diagnosed digestive conditions? – IBS, Crohn's, Ulcerative Colitis etc.? Problems with mouth, gums, tongue?
(v) MUSCULOSKELETAL	Any muscle or joint pain? Muscle or joint stiffness? Muscle spasms or cramps? Numbness or tingling? Neck or back pain? Have you been diagnosed with arthritis / osteoarthritis?
(vi) RESPIRATORY SYSTEM	Do you experience shortness of breath? Do you have a persistent cough? Do you have, or ever had asthma? Suffer from hay fever, sinusitis etc.?

(vii) REPRODUCTIVE SYSTEM (WOMEN)	Do you experience any PMS? Do you experience any menstrual pain? Irregular periods? Heavy or light periods? Infertility? Menopausal symptoms – hot flushes, vaginal dryness etc.?
(viii) MOOD	Do you experience mood swings? Depression? Anxiety or nervousness? Memory loss/confusion? Agitation? Stress levels?
(ix) CVD – CARDIOVASCULAR	Do you have high or low blood pressure? High cholesterol? Episodes of chest pain or palpitations? Any history of heart attack, stroke or CVD? Poor circulation – cold hands, feet? Blood disorders, anaemia, varicosities etc.?
(x) INTEGUMENTARY SYSTEM	Dry or oily skin? Do you bruise easily? Any skin conditions? – eczema, psoriasis, dermatitis, tinea, warts, rashes, acne etc.?
(xi) ENDOCRINE SYSTEM	Thyroid – hyper/hypothyroidism? Hyper / Hypoglycaemia? Diabetes? Difficulty putting on weight or losing weight?

6. DIET

	TYPICAL MEAL INCLUDING DRINKS	**TIME OF DAY** (typically)
Breakfast		
Lunch		
Dinner		
Snacks		
Water/liquids		
Foods avoided?		
Food allergies?		
Cravings?		
Other		

(This section to be completed by your naturopath)

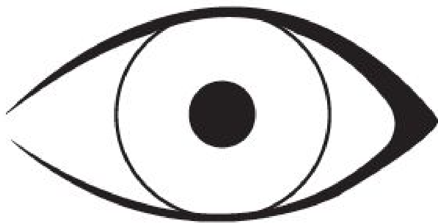
7. PHYSICAL EXAMINATION/OTHER SIGNS

Height:	Weight:
Desired weight:	Pulse (beats/min):
Blood pressure – right arm:	Blood pressure – left arm:
Breathing:	Blood type:
Skin:	Nails:
Teeth:	Tongue:
Breath:	Odour:
Perspiration:	Posture:
Disposition:	Appearance:

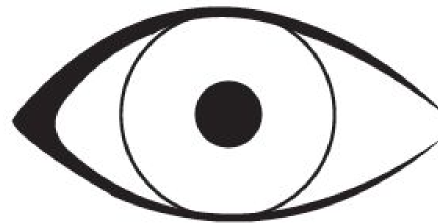
IRIS

Colour:	Texture:

RIGHT



LEFT



(This section to be completed by your naturopath)

9 .GOALS	
Short term goals (List)	Potential barriers to achievement of goals
1.	
2.	
3.	
4.	
5.	

Long term goals (List)	Potential barriers to achievement of goals
1.	
2.	
3.	
4.	
5.	

(This section to be completed by your naturopath)

10 .HERBAL PRESCRIPTION			
BOTANICAL NAME OF HERB	**RATIO**	**QUANTITY (mls)**	**ACTION OF HERB/REASON FOR PRESCRIBING**

Patient dosage (e.g. mls/day/bid/tid; am/pm; before/after meals):

No. of days supply of herbs:

Dispensed by (name):

11.SUPPLEMENTS		
NAME OF PRODUCT	**SIZE OF BOTTLE/PACKET/ CONTAINER**	**ACTION OF SUPPLEMENT/REASON FOR PRESCRIBING**

Patient dosage & Instructions (e.g. tablets/day; am/pm; before/after meals):

No. of days supply of the product:

Dispensed by (name):

(This section to be completed by your naturopath)

12. FLOWER ESSENCES		
NAME OF PRODUCT	**SIZE OF BOTTLE**	**REASON FOR PRESCRIBING**

Patient dosage & Instructions (e.g. no. drops/day; am/pm):

No. of days supply of product:

Dispensed by (name):

13.LIFESTYLE ADVICE

14.ANY SUPPORTIVE STRATEGIES/REFERRAL (Self-care advice and if referral to a medical doctor or another health professional is required).

15.CAUTIONS/CONTRAINDICATIONS (Record any precautions or contra-indications and make appropriate adjustments to your treatment plan).

	Date:
	Date: