Today's Date……

Patient to fill in before consultation

The Naturopaths Confidential Health Questionnaire

Name:_____Age_____Birthdate_____
Address_____Town_____
Telephone Home_____ Work _____ Mobile:_____
Email (***please print clearly***):_____Occupation_____
Relationship Status_____Children_____ Their ages_____Skype:_____

Your main complaints are *(the reason/s why you have come to this clinic):*
……
……

(Further; please tick any of the following boxes If they apply to you, especially if in the past 6 months):

☐ Flatulence	☐ Burping	☐ Allergies	☐ Coughs
☐ Bloating	☐ Reflux	☐ Colds & Flu	☐ Frequent infection
☐ Indigestion	☐ Vomiting	☐ Sore throat	☐ Ear problems
☐ Nausea	☐ Diarrhoea	☐ Bronchitis	☐ Frequent antibiotics
☐ Appetite problem	☐ Feel unwell often	☐ No energy	☐ Sinus
☐ High blood pressure	☐ Hemorrhoids	☐ Can't Sleep	☐ Palpitations
☐ Cholesterol high	☐ Blackout/faint	☐ Pins & needles	☐ Headaches
☐ Low blood pressure	☐ Heart disease	☐ Numbness	☐ Epilepsy
☐ Fluid retention	☐ Migraines	☐ Depression	☐ Diabetes
☐ Eczema	☐ Cold hands & feet	☐ Nervous tension	☐ Easily angered / irritable
☐ Psoriasis	☐ Menopause	☐ Heart problems	☐ Arthritis
☐ Menstrual complaint	☐ Weight gain	☐ Hair loss	☐ Boils or skin infections
☐ Cravings (for sweet)	☐ Cramps	☐ Urinary infection	☐ Itching anywhere
☐ Urinary problems	☐ Skin rashes	☐ Pre menstrual	☐ Cancer diagnosis
☐ Constipation	☐ Giardia	☐ Hepatitis	☐ Varicose veins

A. Do you react to perfumes, chemicals, household cleaners or any other substances? _____

B. Do you take any **supplements or medicines**?_____
_____

C. Do you **smoke or drink**? (*Or have in the past*)_____

D. Have you had **any surgery or operation**?_____

E. Please briefly **describe below the foods, snacks and drinks you consume daily**:

Breakfast	**Lunch**	**Evening Meal**	**Snacks or Treats**	**Drinks**