

SURNAME:		DATE today:		Current Medicines	
FIRST NAMES:		DOB:			
ADDRESS:		AGE:			
		Your GP:			
PHONE HM:		MOBILE:			
PHONE WK:		EMAIL:			
FAX:					
List Past Medical History		Family History			Current Supplements
	date	Father:	Mother:	Siblings	
Occupation now		Dental Health			Medicine allergies
Occupations in past		Amalgams how many?			
		Root Canals ?			
		Other ?			
Special tests or procedures					Food intolerances
Type	Date	Why	Result		
Colonoscopy					
Gastroscopy					
MRI					
CT Scans					
Mammography					
Ultrasound				Chemical intolerances	
ECG					
Angiogram					
Bone Density					
Hair Analysis					
Other tests?				Occupational Chemical Exposure past or current	
Lifestyle		Leisure Time ✓		Exercise ✓	
My work is ✓	My home life is ✓	A lot		A lot	
High Stress	High Stress	Occasional		Occasional	
Low Stress	Low Stress	Rare		Rare	
					✓ Tick which type of Diet?
OFFICE USE					NZ Normal
					Vegetarian/Vegan
					Low carb
					Not very good
					Other --
					✓ Tick if you eat or use -
					Artificial sweeteners
					Caffeinated drinks
					Energy drinks
					Perfume/aftershave etc
					Anti-perspirants
					Environmental
					How old is your home -
					It is - dry damp
					Weed/insect sprays

General Quality of Life Assessment

Go through quickly and put a ✓ somewhere on the line where you rate :

	Excellent	Poor
My overall health	=====	
Energy level overall	=====	
Morning energy	=====	
Sleep pattern	=====	
Concentration	=====	
Memory	=====	
Mood	=====	
Weight	=====	
Appetite	=====	
Exercise	=====	
Motivation	=====	
Body shape	=====	

✓

Do you feel the cold	Yes	No	Just right
Do you feel the heat	Yes	No	Just right

WHAT ARE THE MAIN HEALTH PROBLEMS THAT CONCERN YOU

1
2
3
4
5
6
Other Comments?

GENERAL HEALTH INFORMATION

Go through and ✓ if you have :

Digestion System ✓		Brain and Nerve System	
heartburn, reflux		anxiety	
bloating		depression	
wind		tinnitus (ear noise)	
abdominal pain		pins and needles	
constipation		numbness	
loose stools		vision problems	
blood in stools		hearing problems	
mucus in stools		poor memory	
irritable bowel		migraines	
mouth ulcers		headaches	
don't like fat		restless legs	
sweet craving		dizziness	
change in bowel habit		vertigo	
intestinal infections		cramps	
Respiratory System ✓		Heart and Circulation	
hayfever			✓
sore throats		angina	
cough		chest pains	
asthma		poor circulation	
sinus trouble		leg clots	
mucus in throat		blood disorder	
chest infections		anaemia	
		short of breath	
		palpitations	
Immune System ✓		swelling of ankles	
skin infections		blood pressure	
sore throats, colds		vein clots	
bladder, kidney			
cold sores		Muscles, Joints ✓	
genital herpes		sore muscles	
thrush (candida)		weakness	
tinea		losing muscle	
other infections ?		pain in joints	
		swelling joints	
Skin	✓	back or neck pain	
acne			
psoriasis		Mental health ✓	
dermatitis		feel depressed a lot	
excema		feel loss of enjoyment	
rashes		memory getting bad	
poor nails		don't feel like living sometimes	
poor hair		cant concentrate as well	
losing hair		poor motivation	
dry skin		wake up early	
excessive aging skin		avoid social contact more	

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