Womens Integrative Health Clinic

Initial Intake Form

PRIVATE AND CONFIDENTIAL

Patient Name:

DOB:

Date:

Practitioner:

List ALL Medications you are currently taking

Name of Medication	Reason for taking	Duration	Dose

List of ALL supplements or herbal medicines you are currently taking

Herb or supplement	Brand	Reason for taking	Duration	Dose

Presenting Complaints (Reason for appointment)

List in order of priority:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Personal Health History

Were you born by caesarean section or vaginally?

Were you breast or bottle fed?

Please list any and all diagnosed illnesses and year of diagnosis:

Details of any hospitalisations/operations and year:

Any times of serious stress or trauma – year:

Family History

Are there any diagnosed illnesses that affect family members? Eg. Mum had arthritis and heart disease

Mother:

Father:

Maternal grandmother:

Paternal grandmother:

Maternal grandfather:

Paternal grandfather:

Siblings:

Aunts and uncles:

Cousins:

Environmental details:

- Do you smoke?
- How many per day?
- How much alcohol do you consume? Eg. Amount per/day/week/month/year
- Do you take recreational drugs?
- If so how often and what kind?
- Are you exposed to any mould in your home or workplace?
- Do you have mercury fillings?
- How many hours a day do you spend on the computer?
- Where is your mobile phone when you are asleep at night?
- Are there any other environmental factors that may be playing a role in your symptoms?
- Occupation?

Review of Body Systems

Nervous system

How many hours of sleep do you have per night?

What is your bed time?

What time do you rise?

Do you have good quality sleep or disturbed sleep?

Do you have trouble falling asleep?

Do you have trouble staying asleep?

How many times a night do you wake?

What do you do when you wake at night?

How do you feel when you wake in the morning?

Are you currently seeing a counsellor/psychologist/psychiatrist?

Plan on seeing a mental health professional as part of your treatment plan?

Stress out of 10

Energy out of 10

Gastrointestinal system

Do you suffer from any of the following?

- Bloating
- Reflux
- Burning mouth
- Mouth ulcers
- Abdominal pain
- Constipation or diarrhoea
- Undigested food in the stool
- Mucus in the stool
- Blood in the stool
- Blood in the toilet bowel
- Blood on the toilet paper
- Haemorrhoids
- Nausea
- Bad breath

How many bowel motions do you have per day?

Describe what your stool is usually like?

Eg. Fully formed, loose, pellets, banana, brown, yellow, green, black, straining, floaters, watery

Immune and respiratory systems

Do you suffer from any of the following? Circle and give details

- Frequent colds and flu
- Recurrent infections
- UTI's
- Sinusitis
- Hayfever
- Eczema
- Food allergies or intolerances
- Psoriasis
- Asthma
- Ear infections
- How many times in the last 5 years have you taken antibiotics?
- Recurrent thrush
- Chronic sore throat
- Have you had glandular fever?
- How long does it usually take to recover from a cold or flu? Days/Weeks
- Wheezing
- Coughing
- Mucus
- Post nasal drip

Integumentary/Skin

Do you suffer from any of the following? Circle and give details

List any concerns you have about your skin here:

- Acne
- Rashes
- Eczema
- Dermatitis
- Psoriasis
- Moles
- Other

Endocrine/hormones

Do you suffer from any of the following? Circle and give details

- When was your last period?
- How many days is your menstrual cycle? Eg. 28 days?
- How many days do you bleed for?
- Do you wear pads or tampons?
- How many times per day do you change?

- Do you often flood?
- Are there clots present and if so what size? Eg. 5 cent or 50 cent size
- What colour is the blood? Dark, light, red, brown..
- Do you experience period pain?
- Do you need pain killers every time you have your period?
- Do you experience symptoms of PMS? Eg. Irritable mood, anxiety or depression, bloating, cravings, insomnia, breast tenderness, pain?
- Have you experienced any weight changes recently? Gained or lost >5kg without trying?
- Do you have cold hands and feet?
- Do you have dry skin?
- Brittle hair?

Cardiovascular system

Do you suffer from any of the following?

- Palpitations
- Shortness of breath on exertion
- Shortness of breath while resting
- Chest pain
- Dizziness
- Hypertension (high blood pressure)
- Hypotension (low blood pressure)
- Racing heart or fast pulse
- When was your last trip to the dentist?
- Swelling or fluid retention in your legs or ankles, hands or feet?

Neurological system

Do you suffer from any of the following?

- Visual disturbances
- Hallucinations
- Dizziness
- Loss of balance
- Headaches
- Tinnitus
- Vertigo
- Memory loss
- Confusion
- Have you ever lost consciousness?
- Pins and needles
- Muscle twitching
- Numbness

- Agitation

Reproductive

Do you suffer from any of the following?

- Number of pregnancies
- Number of children
- Number of miscarriages
- What form of contraception do you use?
- Are you pregnant or breast feeding?
- Are you planning pregnancy?

Musculoskeletal system

Do you suffer from any of the following?

- Sore muscles
- Injuries
- Any loss of mobility?
- Nodes or growths?

Renal system

Do you suffer from any of the following?

- Urinary urgency
- Urinary frequency
- How many times do you wake through the night to urinate?
- Burning or stinging on urination
- Discharge
- Itching
- Unpleasant odour
- Dark smelly urine
- Blood in urine
- Low back pain

Typical Diet

	During the week	Weekends
Breakfast Time:		
Lunch Time:		
Dinner Time:		
Snacks		
Daily fluid intake List coffee, tea, soft drink, water, juice and alcohol		

General dietary information:

dietary restrictions?

do not eat?

favourite foods?

vegetarian or vegan?

per week consume red meat?

per week do you consume fish?

What kind of oil do you use when cooking?

Are there any foods that you suspect or notice that you have a reaction to?

How many times a week do you eat out?

What do you choose to eat when you eat out?

Do you ever skip meals and if so how often?

Do you go for long periods without eating?

Do you buy organic fruit and vegetables?

Do you drink tap water?

What is your weekly food budget?

Anthropometrics

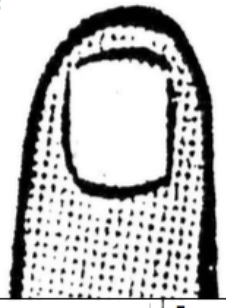
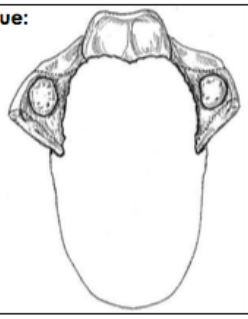
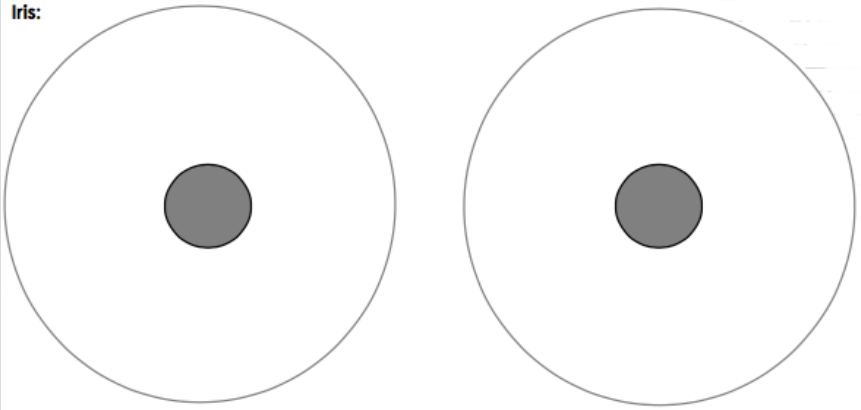
Current weight:

Height:

BMI:

BMI = weight in kg / height in metres x height in metres

Physical Examinations

Blood Pressure:	**Pulse:**	**Temperature:**	**Respiratory Rate:**
Circulation:		**Nail:** 	**Tongue:** 
Skin obs:			
Weight (kg):	**Waist (cm):**		
Height (m):	**Hip (cm):**		
BMI:	**WHR:**		
Iris: 		**Energetics:**	
		Digestion:	
		Elimination:	

What are your long term health goals?

Is there a time that you can pin point that you might say “I have never felt well since…..”

Other relevant: