O2wellness

NEW PATIENT FORM

NAME: _____

ADDRESS: _____

SUBURB: _____ P/CODE: _____

EMAIL: _____ PHONE: _____

DOB: _____ GENDER: _____

OCCUPATION: _____

CURRENT HEIGHT & WEIGHT

HEIGHT	WEIGHT	DATE

MAIN COMPLAINT - *What lead you to seek an appointment / treatment?*

_____

_____

_____

_____

HEALTH CONDITIONS – *Have you been diagnosed with any health conditions?*

_____

_____

_____

_____

MEDICAL INFORMATION

Current medications? *Please list all pharmaceutical medications/prescriptions*

[1] _____ [5] _____

[2] _____ [6] _____

[3] _____ [7] _____

[4] _____ [8] _____

Current supplements? *Please list all supplements including OTC medications*

[1] _____ [5] _____

[2] _____ [6] _____

[3] _____ [7] _____

[4] _____ [8] _____

Do you have any allergies? *Include food, environmental or chemical etc…*

_____

_____

_____

_____

Do you get seasonal allergies? What provokes them? Please explain.

_____

_____

How do you normally manage your allergies?

_____

_____

MEDICAL INFORMATION

Have you had any operations? *List dates and procedures.*

[1] _____ [4] _____

[2] _____ [5] _____

[3] _____ [6] _____

Have you had any antibiotics in the last few years? *If yes, how often and what for*

_____

_____

_____

DENTAL

DO YOU HAVE FILLINGS?	HOW MANY?	WHAT TYPE?

IMMUNISATIONS

List the last Immunisations you had and when they were…

☐ Hepatitis B ☐ Diphtheria ☐ Tetanus ☐ Polio

☐ DTPa ☐ MMR ☐ Pertussis ☐ Pneumococcal

☐ Chicken Pox ☐ Shingles ☐ Meningococcal ☐ Q Fever

☐ Rotovirus ☐ HPV ☐ Flu Vaccine _____

☐ Other _____

Any reactions?

_____

MEDICAL INFORMATION

Have you or **do you currently** suffer from any of the following? *Please select all that apply.*

☐ Reflux	☐ Bloating	☐ Stomach Pain	☐ Wind
☐ Poor sleep	☐ Frequent waking	☐ Fatigue	☐ Noise intolerant
☐ Asthma	☐ Eczema	☐ Allergies	
☐ Tonsillitis	☐ Ear Infection	☐ Sinus Infection	☐ Post Nasal Drip
☐ Gastro	☐ Diarrhoea	☐ Constipation	☐ Candida/Thrush
☐ Seizures	☐ Memory Loss	☐ Stutter / Stammer	
☐ Glandular fever	☐ Chicken pox	☐ Shingles	☐ Pins & needles
☐ Chest Infection	☐ Pneumonia	☐ Recurrent Antibiotics	
☐ Dry hair / skin	☐ Weak nails	☐ Weight issues	☐ Colds hands/feet
☐ Overheated	☐ Puffy hands/feet	☐ Joint pain	☐ Weak muscles

EMOTIONAL

How would you describe your mood? *Please select all that apply.*

☐ Sad	☐ Angry	☐ Happy
☐ Stressed	☐ Defiant	☐ Easy Outburst
☐ Withdrawn	☐ Other	_____

Have you had any significant life changes lately? *i.e. Moving, death in family, changed jobs etc…*

_____

_____

_____

_____

MEDICAL INFORMATION

Any history of any of the following:

CONDITION	YOU	FAMILY	INFORMATION
Breast Cancer	☐	☐	_____
Fibrocystic Breasts	☐	☐	_____
Ovarian Cancer	☐	☐	_____
Endometriosis	☐	☐	_____
Uterine Cancer	☐	☐	_____
Thyroid Issues	☐	☐	_____
Fibroids	☐	☐	_____
PCOS	☐	☐	_____
Abnormal Papsmear	☐	☐	_____
Polyps	☐	☐	_____
Bowel Cancer	☐	☐	_____
Prostate Issues	☐	☐	_____
Testicular Issues	☐	☐	_____
Miscarriage(s)	☐	☐	_____
Stillbirth(s)	☐	☐	_____
Depression / Anxiety	☐	☐	_____
Heart Issues	☐	☐	_____
Diabetes	☐	☐	_____
Coeliac / Crohns	☐	☐	_____
Autoimmune	☐	☐	_____
Other	☐	☐	_____

Is there a family history of any illness, allergies or disease not listed above? Please list.

_____

_____

HORMONES

Have you ever used any of the following:

☐ Mirena ☐ Diaphragm ☐ Contraceptive Pill ☐ Morning After Pill

☐ HRT ☐ Other (specify) _____

☐ Hormone Cream/Gel (specify) _____

☐ Bio-identical hormones (specify) _____

[Females only if applicable]

LAST PERIOD (DAY1)	DURATION	CYCLE LENGTH

At what age did you get your first period? _____

Have your gone through menopause? ☐ ☐ if so, when? _____

Are your periods regular? ☐ ☐

Do you get pain during period or ovulation? ☐ ☐

Do you experience any of the following?

☐ PMT ☐ Sore breasts ☐ Clotting ☐ Bowel pain

☐ Sweating ☐ Night sweats ☐ Brown blood (old)

☐ Other (specify) _____

BEHAVIOURAL & SENSORY *- Manly for children*

☐ Hand flapping	☐ Rocking	☐ Toe walking	☐ OCD	☐ ODD
☐ Blinking at lights	☐ Lines up objects	☐ Spinning wheels	☐ Eye contact issues	
☐ Speech issues	☐ Language delay	☐ Delayed	☐ Sensory processing	
☐ Reading issues	☐ Writing issues	☐ Math's issues	☐ Fussy eater	

Did you meet all the normal milestones?

☐ Sitting	☐ Standing	☐ Walking	☐ Talking

ENVIRONMENTAL

Have you ever been bitten by and/or reacted to any of the following?
Some reactions may include; swelling, rash, itch, lump etc…

EXPOSURE	YES	DETAILS – List reaction or treatment if any.
Mosquito	☐	_____
Sand fly	☐	_____
Snake	☐	_____
Spider	☐	_____
Tick	☐	_____

Do you use, have or live near;

EXPOSURE

☐ Chemicals	☐ Weed Spraying	☐ Bleach	☐ Cleaning chemicals
☐ Power lines	☐ Phone tower	☐ Asbestos	☐ Live near mine
☐ Heavy metals	☐ Mould	☐ Coal / tar	☐ Hairspray/perfume
☐ New carpet	☐ New kitchen	☐ New car	☐ Renovated recently
☐ New furniture	☐ New paint	☐ Animals	☐ Petrol

DIET INFORMATION

What is your normal diet?

Breakfast: _____

Morning Tea: _____

Lunch: _____

Afternoon Tea: _____

Dinner: _____

Snacks: _____

Beverages: _____

	YES	NO	QUANTITY
Water?	☐	☐	_____
Tea / Coffee?	☐	☐	_____
Do you smoke?	☐	☐	_____
Alcohol?	☐	☐	_____
Crave sugar?	☐	☐	_____
Crave salt?	☐	☐	_____
Tired in afternoon?	☐	☐	_____
Do you exercise?	☐	☐	_____
Sleep well?	☐	☐	_____
Suffer insomnia?	☐	☐	_____

DIET INFORMATION

Do you react to any of the following foods?
What foods have you identified as an issue? Please list and describe reaction.

☐ Gluten	☐ Dairy	☐ Lactose	☐ Soy
☐ Corn	☐ Peanuts	☐ Tree nuts	☐ Histamine Foods
☐ Salicylates	☐ Amines	☐ Glutamates	☐ Oxalates
☐ Sulfur	☐ Chemicals	☐ Preservatives	☐ Colourings
☐ Flavourings	☐ Other (specify)	_____	

HEALTH PROVIDERS & PRACTITIONERS

NORMAL DOCTOR

NAME: _____

PRACTICE: _____

EMAIL: _____ PHONE: _____

SPECIALISTS AND/OR PAEDATRICIAN

NAME: _____

PRACTICE: _____

EMAIL: _____ PHONE: _____

OTHER:

NAME: _____

PRACTICE: _____

EMAIL: _____ PHONE: _____

OTHER IMPORTANT INFORMATION

_____

_____

_____

_____

_____

☐ Have you seen a Naturopath before?

CONSULTATION AGREEMENT

What are you agreeing to? By submitting this form, you agree and consent to the following --

1. That your first consultation will consist of a history overview, symptom assessment and a lifestyle/dietary evaluation
2. That you should never commence a natural medicine supplement program (i.e. liquid, tablet, capsule or diet) without first consulting with a professional to ensure your own safety along with mitigating side effects that may occur
3. You understand naturopathic treatment isn't a short-term process, or quick-fix solution
4. You understand that there is a financial obligation for the cost of ongoing consultations, testing and supplementation
5. You understand that all costs are privately billed i.e. there are no Medicare rebates or bulk billing available on any service offered
6. You agree to disclose all medications, prescriptions or supplementation you are taking, whether legal or illegal
7. If you do not disclose such medications [6] you understand adverse reactions may occur that we cannot be held responsible for
8. You understand that self-prescribing (i.e. consulting family, friends or "Dr. Google") and/or taking supplements not prescribed, you do so at your own risk

Signed _____ Name _____ Date _____

NEXT STEPS:

1. Submit this form along with any previous test results via email to info@o2wellness.com.au
2. Make an appointment if you haven't already done so via the website www.o2wellness.com.au