Wellness
Perth Natural Medicine
Telephone: (08) 9479 5310

Full Name:_____ Title:_____ DOB:_____ Age:_____
Preferred Name:_____ Consent of Guardian if under 18:_____
Address:_____ Email:_____
Mobile:_____ Private Health Insurance with Naturopathic Cover:_____
Next of Kin:_____ Contact Details:_____ Relationship of Next of Kin:_____
Child:_____ Age:_____ Child:_____ Age:_____
Child:_____ Age:_____ Child:_____ Age:_____
Child:_____ Age:_____ Child:_____ Age:_____
Occupation:_____ Work Hours:_____ Occupational Hazards:_____
Family Physician:_____ Ph:_____ Fax:_____
Height:_____ Weight:_____ Blood Group:_____
Pregnant/Breastfeeding (Yes/No/Trying):_____
Known Allergies/Sensitivities:_____
Reason for visit:_____

_____

_____

_____

Typical Daily Diet Sample:

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____ Other/Special Dietary Considerations:_____
Water:_____ Tea:_____ Coffee:_____
Soft Drinks:_____ Energy Drinks:_____ Alcohol:_____
Juice:_____ Artificial Sweetener:_____ Water Filtered:_____

Lifestyle Questions:

Daily/Weekly Exercise Regime:_____
_____ Smoking/History of Smoking:_____
Usual bedtime:_____ Usual time awake:_____ Wake during night:_____
Length of time to fall asleep:_____ Do you wake feeling refreshed:_____
Do you have/had any dental amalgam fillings (dark silver, metal, mercury fillings):_____
Usual number of colds per year:_____ How long do they last:_____
Personal Medical History (illnesses, diagnoses, surgeries):_____

_____

Family Medical/Health History:

Family Member (i.e. Mother):	Medical/Health History:

Please tick/cross/mark if you currently have, or have in the past experienced any of these symptoms:

Symptom:	Past Symptom	Present Symptom	Frequency/Details:
Acne			
Anxiety			
Arthritis			
Asthma			
Bloating after meals			
Blood Pressure			
Cancer			
Chronic Fatigue			
Cold Hands/Feet			
Constipation			
Depression			
Diabetes			
Diarrhoea			
Dizziness			
Ear Infections			
Eczema			
Flatulence/Wind			
Fluid Retention			
Hayfever			
Heartburn/Reflux			
Heart Disease			
Headaches			
Hepatitis			
Indigestion			
Infertility			
Iron Deficiency			
Menopause			
Migraines			
Miscarriage			
OCD-tendencies			
Perfectionist			
PMS Symptoms			
Poor Circulation			
Poor Concentration			
Poor Memory			
Sinus Issues			
Stress			
Sugar Cravings			
Thrush			
Tiredness			
Thyroid Issues			
Weight Issues			
Other:			
Other:			

Symptom Severity Rating

This chart will be utilised to rate the severity of each current symptom; we will then re-rate each symptom within most appointments to track your improvement.

Instructions:

1. List each Present Symptom marked on the previous page under the "Symptom List" column.
2. Rate each symptom in the Present Week column on a scale of 1-10 for how severe the symptom is this week (10 = symptom is severe, 1 = symptom is mild).

	Present week	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Symptom List: (10 = severe)	**Rated 1-10:**	**Rated 1-10:**	**Rated 1-10:**	**Rated 1-10:**	**Rated 1-10:**	**Rated 1-10:**	**Rated 1-10:**	**Rated 1-10:**
Example: Anxiety	*8*							
Stress – home environment								
Stress – work environment								
Energy levels								
(1 = poor, 10 = good)								
Quality of sleep								
Energy – morning								
Energy – late morning								
Energy – early afternoon								
Energy – late afternoon								
Energy – evening								
Stress-coping ability								

Current Medication/s:

Drug/Medication:	Purpose for Taking:	Dosage:	Time of Day:	Month/Year Began:

Current Health Supplement/s:

Supplement:	Purpose for Taking:	Dosage:	Time of Day:	Month/Year Began:

- *I confirm that the information I have provided is true to the best of my knowledge.*
- *I have read and understood the Appointment Policy – a minimum 48 hours' notice is required to cancel or reschedule an appointment.*
- *I understand that my practitioner, Kylie Robshaw, is a naturopath and medical herbalist, not a medical doctor.*
- *Accordingly, I understand that Kylie Robshaw is not able to diagnose or treat medical conditions, but will be able to effectively assist me with my health and wellbeing.*

Patient's Signature:_____ Date:_____

Please return form via email, fax or postal service at least two business days prior to your first visit.

Address: 19 Gillings Parade, Wattle Grove WA 6107.
Email: reception@wellnessperth.com.au
Fax: (08) 9359 1136