



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:			

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