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

Wellness Perth Natural Medicine

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Kylie Robshaw MNHAA
Naturopath & Medical Herbalist
BHSc (Comp Med), Adv.Dip.(Nat), Adv.Dip.(WHM)
Provider Numbers: 1154583X, 1510113W

Date:_____

Att: To Whom It May Concern,

FULL NAME: _____

DATE OF BIRTH: _____

CURRENT ADDRESS: _____

May we please receive copies of our patient's blood test and pathology results from _____ sent online electronically via download system:

- Western Diagnostics – Medway and MQLink, via HL-7 format.
- Clinipath - Sonic Dx and FETCH.
- ACL – eresults.clinicallabs.com.au online and SMSC.
- Emailed to reception@wellnessperth.com.au; and/or faxed to (08) 9359 1136.

Please find our patient's signed authority below.
Contact us directly with any queries on (08) 9479 5310.

Thank you for your assistance.

Kylie Robshaw MNHAA
BHSc (Comp Med), Adv Dip (Nat), Adv Dip (WHM)
Naturopath & Medical Herbalist
Member NHAA 155008

I, _____ give permission for the above to receive copies of my past and present diagnostic test results including pathology and radiology as requested.

Signed:_____ Date:_____