MACQUARIE NATURAL HEALTH

Dubbo Specialist & Rebabilitation Centre
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Welcome to Macquarie Natural Health.

Thank you for making an appointment and taking the first step to restoring your health.
I would like to welcome you to my clinic and confirm your appointment time with us.

My name is Liza Twohill and I am the principal of Macquarie Natural Health. At Macquarie Natural Health we offer evidence based functional medicine with an emphasis on nutrition and environmental health.

Nutritional medicine is a complementary medicine that is concerned with the impact nutritional and environmental factors have on the functioning of the human body. It is a science-based field of healthcare that systematically looks at the person as a whole and aims to treat the underlying problem rather than a quick fix approach.

As part of this approach I would encourage you to take a few moments prior to your consultation to consider your expectations. From my experience it helps to prepare specific questions for me, record medicines you are currently taking and some notes about the symptoms you may be experiencing. If you have any recent pathology test results, please bring them along with you. This will ensure we make the most out of your consultation.

The following forms are to be completed prior to your appointment;

Adults;
MNH Adult Questionnaire
MNH Family History
MNH Metabolic Screening Questionnaire
MNH Dietary Record Sheet

Child;
MNH Child Questionnaire
MNH Dietary Record Sheet
MNH Family History

At your convenience prior to your appointment please fill out these forms and email them back to us at enquiries@macquarienaturalhealth.com.au. Alternatively, you may drop them in to our clinic at 205 Darling Street. Please have this completed at least one day earlier than your appointment. We realise that the questionnaire is comprehensive and that the information may be sensitive, however it is an important tool, assisting us both in getting the most from your appointment. All information is held in the strictest confidence.

Once again thank you for choosing to see us and we look forward to seeing you very soon.

Yours Sincerely,

Liza Twohill

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CONFIDENTIAL PATIENT QUESTIONNAIRE

Please complete the following questionnaire. Your response remains confidential and will provide information for your practitioner to use in your assessment and treatment.

Practitioner: _ _____ Appointment Date: ___/___/___ Time: ___:___

Title		Date of Birth	
First/Second Names		Surname	
Home Address			
Suburb/Town		State	Postcode
Home: ( )	Work ( )	Mobile:	
Doctors Details:		Private Health Fund	
Email Address			
Height (cm)	Weight (kg)		
Next of Kin	Relationship	Telephone No.	
How did you hear about Macquarie Natural Health? Please tick the category below.			
Advertisement	Article	Brochure/Flyer/Poster	Email
Facebook	Friend/ Relative	Gift Voucher	Pharmacy/Health Food
Practioner referral	TV/ Radio	Walk by Signage	Website
Other (please specify)			

GENERAL DETAILS

Please list the main problems you are experiencing and/or reasons for this appointment.
_____
_____
_____
_____
_____

What do you believe the problem may be due to?
_____
_____
_____

What kind of treatment(s) have you tried for the problem(s) listed above? Please detail any relevant testing or investigations and bring relevant copies with you to your consultation.
_____
_____
_____
_____
_____

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When was the last time you felt truly well?

What do you expect from your consultation today?

What do you think can help you?

PAST MEDICAL HISTORY

Please circle as appropriate.

Illness/Medical Problem	Present	Past
Heart/Vascular Disorder	YES	YES
Blood Disorder	YES	YES
High Blood pressure	YES	YES
Cancer	YES	YES
Arthritis	YES	YES
Diabetes	YES	YES
Liver Disease	YES	YES
Kidney Disease	YES	YES
Asthma	YES	YES
Epilepsy	YES	YES
Hepatitis	YES	YES
Glandular Fever	YES	YES
Dysentery	YES	YES
Sexually Transmitted Diseases Please Specify	YES	YES
Other conditions Please Specify	YES	YES
Operations Please Specify	YES/NO	YES/NO
Pregnancies	YES/NO	YES/NO
Exposure to chemicals or toxins Please Specify	YES/NO	YES/NO
Amalgam Fillings	YES/NO	YES/NO
Frequent antibiotic use	YES/NO	YES/NO
Previous long-term medications	YES/NO	YES/NO

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NUTRITIONAL SUPPLEMENTS (vitamins, minerals etc) HERBAL MEDICINES, HOMOEPATHIC REMEDIES

Name	Dosage

CURRENT MEDICATIONS (prescription and non-prescription)

Name	Dosage

ALLERGIES/SENSITIVITIES (including medications, foods, dust mites, grasses, chemicals)

Allergies/Sensitivities	Treatment

SOCIAL HISTORY

Occupation	
Marital Status	
Cigarettes/Tobacco (strength & amount)	
Alcohol (type & amount)	
Recreational Drugs	
Exercise (type, duration & frequency	
Relaxation Techniques (eg. Meditation, yoga, tai chi)	

DIET

Do you follow a specific diet? Please circle	YES/NO
If yes please specify. Eg Low Fat Low carbohydrate, blood group, vegetarian etc	

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What did you eat yesterday? Please complete the table below.

Breakfast			
Lunch			
Dinner			
Snacks			
Sugar (tsp/day)	Tea (cups/day)	Coffee (cups/day)	Soft drinks (per day)
Water (glasses/day)		Other Drinks	

Was this a typical day? Please Circle YES/NO

Please list the foods you **CRAVE.**	Please list the foods that you **AVOID.**

IMMUNISATION HISTORY Please record any immunisation you have received.

TYPE	DATE	TYPE	DATE

CURRENT SYMPTOMS

Please tick the box to the right of any condition you are **CURRENTLY EXPERIENCING**

GENERAL		WEIGHT		EYES		EARS	
Fatigue		Weight Gain		Watery/Itchy		Itchy	
Apathy/Lethargy		Difficulty losing weight		Painful/red		Ear Aches	
Hyperactivity		Fliud Retention		Sticky eyelids		Infections	
Poor Appetite		Binge Eating		Blurred Vision		Discharge	
Hypoglycaemia		Compulsive Eating		Dry Eyes		Tinnitus (ringing)	
Poor Sleep/Insomnia		Craving for certain Foods		Deteriorating Vision		Hearing Loss	
Sleep Apnoea		Weight Loss					
Excessive Thirst		Eating Disorders		**NOSE**		**LUNGS**	
Stress				Congested/Blocked		Shortness of Breath	
Easy Bruising				Poor sense of smell		Cough	
EMOTIONS		**MIND**		Sinus Problems		Sputum	
Anxiety		Poor Memory		Hay fever/Allergy		Blood	
Depression		Poor concentration		Sneezing		Chest Tightness	
Mood Swings		Confusion		Excessive mucus		Wheeze	
Panic Attacks		Poor Comprehension		Post nasal Drip			
Anger, Irritability		Brain Fog'					

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DIGESTIVE SYSTEM		NERVOUS SYSTEM		GYNAECOLOGICAL		GENITO-URINARY	
Indigestion		Headaches		Breast Pain			
Heartburn/reflux		Migraines		Breast Lumps			
Bloating		Faintness		Breast Implants			
Feel full easily		Dizziness		Regular Periods		Urgent Urination	
Burping		Numbness		Irregular Periods		Kidney Pain	
Flatulence		Tingling/Pins & Needles		No Periods		Difficulty passing Urine	
Nausea		Poor Co ordination		Heavy Periods		Incontinence	
Vomiting		Feel Cold easily		Menstrual Clots		Loss of Libido	
Difficulty Swallowing		Cold Hands & Feet		Period pain/cramps		Passing Urine Frequently at Night	
Diarrhoea				Painful Intercourse		Erectile Dysfunction	
Constipation				Vaginal Discharge		Frequent Urination	
Piles (Haemorroids)		**HAIR/NAILS**		Thrush		Discharge	
Mucus		**HAIR**		Menopausal		Blood in Urine	
Abdominal/Stomach pains or cramps		Dry Hair		PMT (Pre Menstrual Tension)		Passing large amounts of Urine	
Rectal Bleeding		Increased Hair Loss		Vaginal Irritation/ soreness		Burning/Discomfort on urination	
Anal Itching		**NAILS**		Hot Flushes			
		Soft		Sweats			
		Break Easily		Vaginal Dryness			
		White Spots					
		Ridged					
		Fungal Infections					

HEART/CIRCULATION		MOUTH/THROAT		SKIN		JOINTS/MUSCLES	
High Blood Pressure		Mouth Ulcers		Acne/Pimples		Pain	
Low Blood Pressure		Cold Sores		Eczema/Dermatitis		Swelling	
High Cholesterol		Cracks at corner of Mouth		Psoriasis		Stiffness	
Palpitations/ Arrhythmia		Hoarseness,loss of Voice		Rosacea		Arthritis	
Calf Pain with Exercise		Gum Disease/ Bleeding		Rashes		Neck Problems	
Chest Pain		Sore Throat		Hives/Urticaria		Back Problems	
Swelling of Ankles		Feeling of Lump in Throat		Dry Skin		Cramps/Spasms	
Poor Circulation		Bad Breathe		Poor Healing		Muscle Twitching	
Varicose Veins		Loss of Taste Sensation		Excessive Sweating		Muscle Tension	
				Body Odour		Muscle Weekness	
				Dandruff		Gout	

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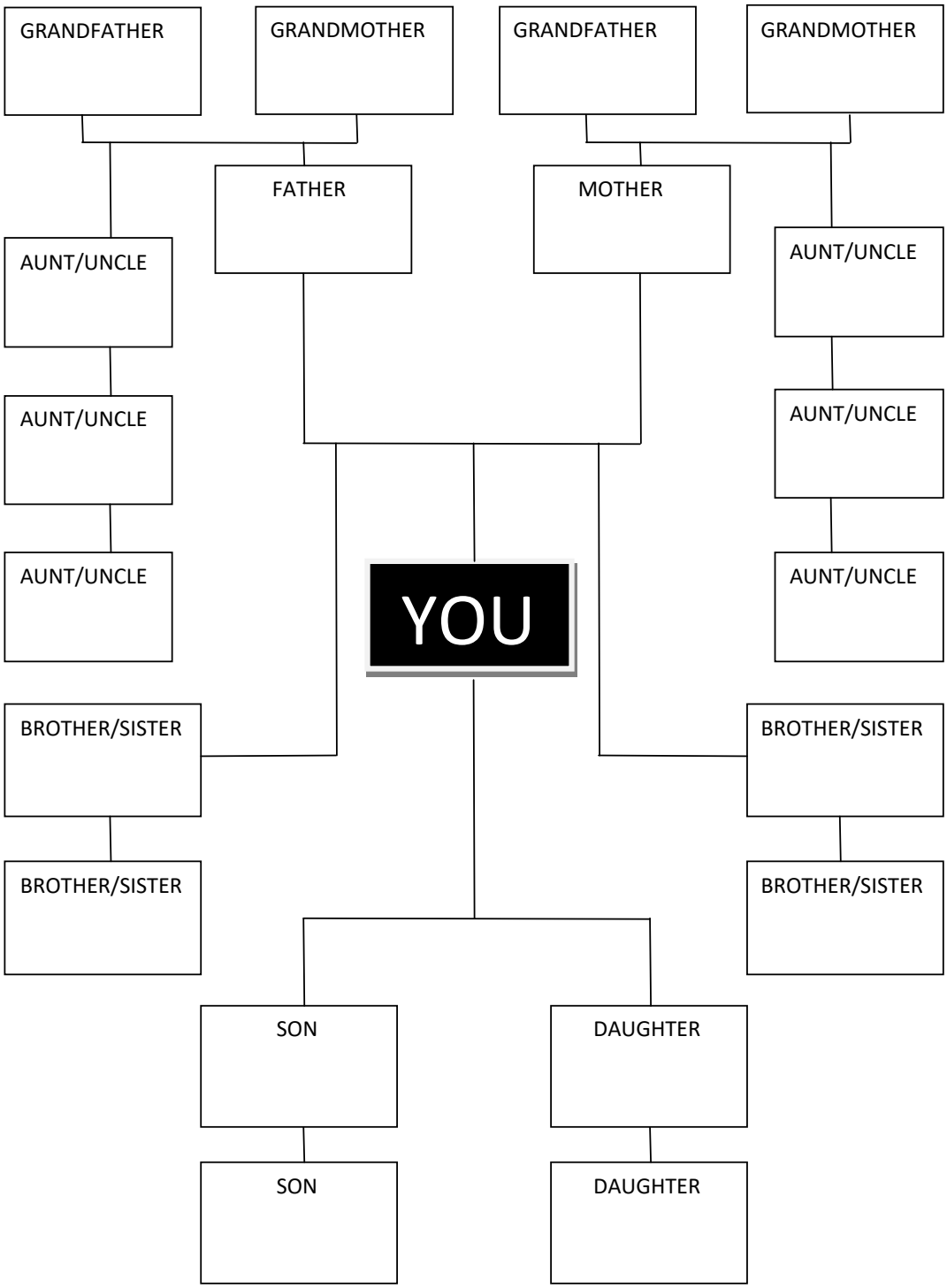
Please complete the chart below indicating only chronic or significant illnesses (eg. Cancer, diabetes, asthma, arthritis, heart disease and blood pressure) within the appropriate box on the family medical history tree.

FAMILY HISTORY



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METABOLIC SCREENING QUESTIONNAIRE

Please rate each of the following symptoms based upon your health profile for the past 30 days.

0 = Never or almost never have the symptom.
1 = Occasionally have it, effect is not severe.
2 = Occasionally have it, effect is severe.
3 = Frequently have it, effect is not severe.
4 = Frequently have it, effect is severe.

DIGESTIVE TRACT	___Nausea or vomiting ___Diarrhoea ___Constipation ___Bloated Feeling ___Belching, or passing gas ___Heartburn ___Intestinal/Stomach Pain	**Total** ____
EARS	___Itchy Ears ___Earaches, ear infections ___Drainage from ears ___Ringing in ears, hearing loss	**Total** ____
EMOTIONS	___Mood Swings ___Anxiety, fear or nervousness ___Anger, Irritability, or aggressiveness ___Depression	**Total** ____
ENERGY/ACTIVITY	___Fatigue/sluggishness ___Apathy, Lethargy ___Hyperactivity ___Restlessness	**Total** ____
EYES	___Watery or itchy eyes ___Swollen, reddened or sticky eyelids ___Bags or dark circles under eyes ___Blurred or tunnel vision (does not include near or far sightedness)	**Total** ____
HEAD	___Headaches ___Faintness ___Dizziness ___Insomnia	**Total** _____
HEART	___Irregular or skipped Heartbeat ___Rapid or pounding Heartbeat ___Chest pain	**Total** _____
JOINTS/MUSCLES	___Pain or aches in joints ___Arthritis ___Stiffness or limitation of movement ___Pain or aches in muscles ___Feeling of weakness or tiredness	**Total** _____
LUNGS	___Chest congestion ___Asthma, bronchitis ___Shortness of breath ___Difficulty breathing	**Total** _____

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Continued METABOLIC SCREENING QUESTIONNAIRE

MIND	___Poor memory ___Confusion poor comprehension ___Poor concentration ___Poor physical co ordination ___Difficulty in making decisions ___Stuttering or stammering ___Slurred speech ___Learning disabilities	**Total** _____
MOUTH/THROAT	___Chronic Coughing ___Gagging, frequent need to clear throat ___Sore throat, hoarseness, loss of voice ___Swollen or discoloured tongue, gums or lips Canker Sores	**Total**
NOSE	___Stuffy nose ___Sinus problems ___Hay fever ___Sneezing attacks ___Excessive mucus formation	**Total** _____
SKIN	___Acne ___Hives, rashes or dry skin ___Hair Loss ___Flushing or hot flushes ___Excessive sweating	**Total** _____
WEIGHT	___Binge eating/drinking ___Craving certain foods ___Excessive weight ___Compulsive eating ___Water Retention ___Under weight	**Total** _____
OTHER	___Frequent illness ___Frequent or Urgent urination ___Genital itch or discharge	**Total** _____

GRAND TOTAL _____

COMMENTS:

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Dietary Record Sheet

Please complete this one week diet record. Please record everything eaten, remembering to state type of milk, bread etc. consumed as well as alcohol, treats, exercise and water.

Name: **Date:**

DAY	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Treats							
Alcohol							
Water (2L)							
Exercise							
Symptoms							