MACQUARIE NATURAL HEALTH

Dubbo Specialist & Rehabilitation Centre
205 Darling Street Dubbo NSW 2830
P: 02 6882 2322
P: 02 6885 1696
F: 02 5820 0260
enquiries@macquarienaturalhealth.com.au
www.macquarienaturalhealth.com.au

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 nutritional & environmental medicine.

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 complete these forms and email them to us at enquiries@macquarienaturalhealth.com.au. Alternatively, you can drop it back to us at 205 Darling Street. Please have these back to us at least one day prior to 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 me and I look forward to seeing you very soon.

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CHILD CONFIDENTIAL HEALTH QUESTIONNAIRE

ALL QUESTIONS ARE IMPORTANT			Date:	
PATIENT INFORMATION				
Child's name:			Birth Date / /	Age: Sex: ❑ M ❑ F
Number of Siblings:	The child's seniority (1st child, 2nd):	Parents/Guardian's Name:		
Contact Details				
Address:		Home Phone no.:		Mobile no.:
Email Address:		Family Doctor:		
What is the reason for your visit?				
How long has your child had this condition?				
If there are aspects of your child's wellbeing that you wou prefer not to discuss in front of them, please State;				

TAKE TIME TO CAREFULLY REMEMBER YOUR CHILD'S & MEDICAL HISTORY BELOW				
Allergies or sensitivities:				
Sleep patterns (restless etc):				
Regular time to Bed:			Regular waking time:	
Bowel Movements:	❑ Daily	❑ or other	❑ pain/discomfort	
Consistency:	❑ normal	❑ hard	❑ loose	❑ alternating (hard/loose)
Caesar birth:	❑ Yes	❑ No		
Breast fed:	❑ Yes	❑ No	If yes, how long?	

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Type of formula/milk used when weaning:

First symptoms noticed at age (e.g. born with thrush; infection at 12 mths; or other problems)

Vaccination history:

Any noticeable connection between symptoms and vaccination? ❑ Yes ❑ No

Tick following and record at what age

❑ reflux at age ( ) ❑ Colic at age ( ) ❑ skin problems at age ( ) ❑ urinary infections at age ( )

❑ ear infections at age ( ) ❑ respiratory infections at age ( ) ❑ oral thrush ( )

❑ hospitalisation at age ( ) ❑ please provide any other significant illness and at what age they occurred.

Tick any symptoms present:

❑ turns out/ daydreams ❑ poor short term memory ❑ itching ❑ restless

❑ complains of stomach discomfort ❑ irritable ❑ enuretic (wets bed) ❑ mood swings

❑ hyperactive ❑ bad breath ❑ has trouble getting to sleep ❑ aggressive

❑ attention deficient (easily distracted or can't concentrate ❑ smelly stool ❑ anxious

❑ more than average flatulence (farting) ❑ sugar cravings ❑ picky eater ❑ fungal infections

❑ fatigues easily ❑ poor motor skills/coordination

Anti-biotic history & other medications

Please list as accurate as possible medication history and age (eg. 5 x anti-biotic's 6-12mths, cortisone cream 2mtns at age

Current medication;

Is your child in new or r and/or renovated decorate bedroom/home (carpets, etc)?

❑ Yes ❑ No ❑ At birth ❑ at age ( )

Chemical sensitivity: If you feel your child is sensitive or reacts to chemicals please state (eg,. Washing powers, sunscreen, perfumes)

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Mother – This is information about the mother

Tick if you have ever had:

❑ measles ❑ chickenpox ❑ mumps ❑ rubella

During pregnancy & birthing:

❑ thrush ❑ alcohol (how much) ❑ smoking (how much daily?)

❑ anti-biotics? ❑ prescriptions medication

Mercury amalgams (tooth fillings)

How many? ( ) Place during pregnancy? ❑ Yes ❑ No

Please state any other fental work undertaken during pregnancy;

Please outline daily food/fluid intake of your child; CHILD'S DIET ONLY

Current diet: please indicate a typical day;

Water (qty): Alcohol (qty): Tea (qty): Coffee (qty):

Soft drink or cordial (qty):

Breakfast: Mid afternoon:

Mid morning: Dinner:

Lunch: Supper:

How did you hear about the clinic?

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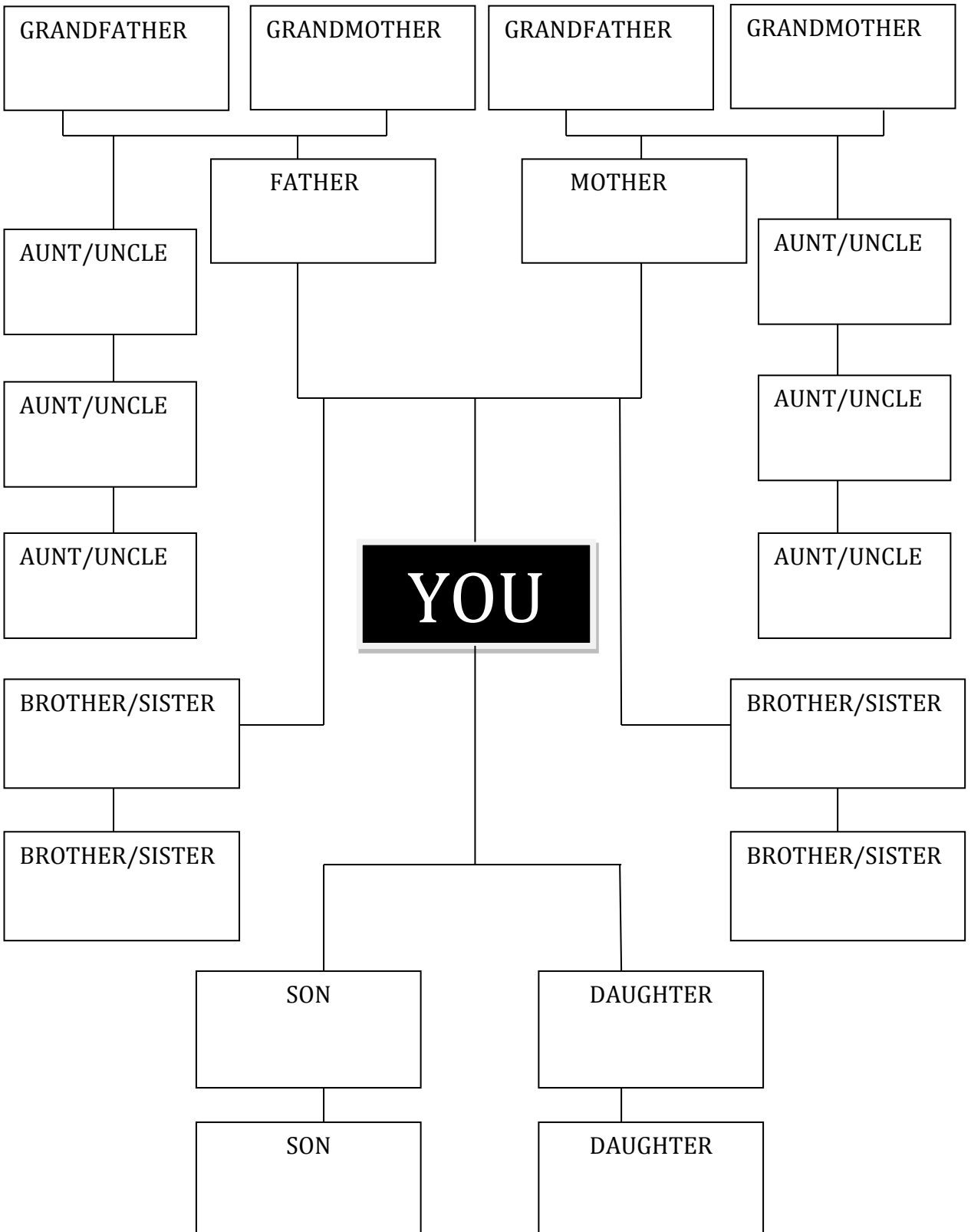
FAMILY HISTORY Please complete the chart below indicating only chronic or significant Illnesses (eg. Cancer, diabetes, asthma, arthritis, heart disease and blood pressure) within the appropriate box on the family medical history tree.



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Dietary Record Sheet: Please complete this one week diet record sheet. Record everything eaten, remembering to state type of milk, bread etc. Consumed as well as alcohol, treats, exercise and water.
NAME: **DATE:**

Day							
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Treats							
Alcohol							
Water (2L)							
Exercise							
Symptoms							