

Client Health & Medical Details Form



Integrated Therapeutic Alignment

Health and Medical Details

Name Date of Birth

Occupation Marital Status

Address Home Phone

Suburb Postcode Work Phone

Email Mobile

Please state briefly why you have come for a health consultation today.....

Please list symptoms of importance to you.....

To give us a complete picture of your health and lifestyle, please complete the following questionnaire

Mark with a where applicable to yourself or circle if your family has a history or circle for both

Condition	<input type="checkbox"/>	Condition	<input type="checkbox"/>	Condition	<input type="checkbox"/>
Allergies/Eczema	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Thrombosis or Phlebitis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Hay fever/sinusitis	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Psychological conditions	<input type="checkbox"/>
Migraines/Headaches	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	Digestive and/or intestinal problems	<input type="checkbox"/>
Urinary/Kidney problems	<input type="checkbox"/>	Hepatitis/HIV/AIDS	<input type="checkbox"/>	Other	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	Cold hands/feet	<input type="checkbox"/>	Dislocations, breaks/fractures	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	Dizziness/blurred vision	<input type="checkbox"/>	Joint pain, arthritis, rheumatism	<input type="checkbox"/>
Menstrual problems	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Medications and Supplements: Are you currently taking any medications? Yes / No

If Yes please provide details

Are you currently taking any herbal or vitamin/mineral supplements? If Yes please provide details

Have you had any illness or operations within the last 12 months? If Yes please provide details

Current Medical Conditions: Briefly state any current medical conditions and tick the boxes that apply

Allergies	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Infection	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	Other					

Please ✓ if you have any of the following:

IMMUNE	LIVER / GALL BLADDER	METABOLIC
Colds/Influenza <input type="checkbox"/>	Hives <input type="checkbox"/>	Fatigue <input type="checkbox"/>
Allergies/Hay fever <input type="checkbox"/>	Itching <input type="checkbox"/>	Weakness <input type="checkbox"/>
Frequent Infections <input type="checkbox"/>	Stools pale/clay colour <input type="checkbox"/>	Dry skin/brittle hair <input type="checkbox"/>
Thrush <input type="checkbox"/>	History of jaundice, Hepatitis <input type="checkbox"/>	Weight gain <input type="checkbox"/>
SKIN	URINARY	Sensitive to heat <input type="checkbox"/>
Skin Problems <input type="checkbox"/>	Frequent urination <input type="checkbox"/>	Sensitive to cold <input type="checkbox"/>
Poor wound healing <input type="checkbox"/>	Poor stream <input type="checkbox"/>	Cold hands and feet <input type="checkbox"/>
ENT	Dribbling urine after urination <input type="checkbox"/>	Craving frequent snacks/sugar <input type="checkbox"/>
Ear Infections <input type="checkbox"/>	Sudden, urgent need to urinate <input type="checkbox"/>	Muscle cramps <input type="checkbox"/>
Tonsillitis <input type="checkbox"/>	Leakage with cough/strain <input type="checkbox"/>	Migraine <input type="checkbox"/>
Sinusitis <input type="checkbox"/>	Getting up at night to urinate <input type="checkbox"/>	MUSCULOSKELETAL
RESPIRATORY	Frequent bladder infections <input type="checkbox"/>	Aches/pains <input type="checkbox"/>
Cough <input type="checkbox"/>	REPRODUCTIVE (MALE)	Joint pain <input type="checkbox"/>
Wheeze <input type="checkbox"/>	Poor beard/hair growth <input type="checkbox"/>	Joint swelling <input type="checkbox"/>
Breathlessness <input type="checkbox"/>	Difficulty sustaining erection <input type="checkbox"/>	Joint stiffness <input type="checkbox"/>
CARDIOVASCULAR	Lack of sexual desire/interest <input type="checkbox"/>	Headaches <input type="checkbox"/>
Chest pains <input type="checkbox"/>	Past sexually transmitted disease <input type="checkbox"/>	NERVOUS SYSTEM
Palpitations <input type="checkbox"/>	REPRODUCTIVE (FEMALE)	Tingling/numbness <input type="checkbox"/>
Breathless with exertion <input type="checkbox"/>	Cycle length (days) <input type="checkbox"/>	Vertigo <input type="checkbox"/>
Dizziness <input type="checkbox"/>	Period length (days) <input type="checkbox"/>	Poor balance <input type="checkbox"/>
Ankle swelling <input type="checkbox"/>	Miss periods? <input type="checkbox"/>	Recent change in vision <input type="checkbox"/>
Varicose veins <input type="checkbox"/>	Pain with/before period <input type="checkbox"/>	Morning headaches <input type="checkbox"/>
Leg pain with exertion <input type="checkbox"/>	Fluid retention with/before period <input type="checkbox"/>	MENTAL
Cold feet <input type="checkbox"/>	Heavy periods <input type="checkbox"/>	Frequent sad feelings <input type="checkbox"/>
Easy bruising <input type="checkbox"/>	Hot flushes <input type="checkbox"/>	Feelings of anxiety / panic <input type="checkbox"/>
UPPER GASTROINTESTINAL	Vaginal dryness <input type="checkbox"/>	Loss of interest / enjoyment <input type="checkbox"/>
Indigestion <input type="checkbox"/>	Recurrent thrush <input type="checkbox"/>	Reduced / broken sleep <input type="checkbox"/>
Belching/burping <input type="checkbox"/>	History of sexually transmitted disease <input type="checkbox"/>	Difficulty concentrating <input type="checkbox"/>
Heartburn/Acid reflux <input type="checkbox"/>	History of abnormal PAP smears <input type="checkbox"/>	Change in appetite <input type="checkbox"/>
Sense of fullness after food <input type="checkbox"/>	Ovarian cysts/breast lumps <input type="checkbox"/>	Pessimistic / guilty thoughts <input type="checkbox"/>
Nausea/Vomiting <input type="checkbox"/>	Fibroids/Endometriosis <input type="checkbox"/>	Thoughts / plans for suicide <input type="checkbox"/>
Stomach pain <input type="checkbox"/>	Excess facial hair/acne <input type="checkbox"/>	Feelings of resentment <input type="checkbox"/>
LOWER GASTROINTESTINAL	Lack of sexual desire/interest <input type="checkbox"/>	
Lower abdominal pain <input type="checkbox"/>	Milk production (not breast feeding) <input type="checkbox"/>	
Excess gas/bloating <input type="checkbox"/>		
Stools hard/dry <input type="checkbox"/>		
Use laxatives <input type="checkbox"/>		
Stools loose/watery <input type="checkbox"/>		
Blood/mucus in stools <input type="checkbox"/>		

COMMENTS:

LIFESTYLE: Please answer yes (Y) or No (N) to the following and how much (quantify daily and/or weekly)

Do you drink?	Y/N	How Much?	Do you smoke	Y/N	How Much?
• Coffee			• Tobacco		
• Tea			• Cannabis		
• Soft drink			Do you	Type	How Often?
• Fruit juice			• Exercise regularly		
• Water			Rate what you think your stress level is		Score 1–10

DIET: Please indicate your general diet in the table below

MEAL TIME	Solids	Liquids
Breakfast		
Mid morning		
Lunch		
Mid Afternoon		
Dinner		
Snacks/Deserts		

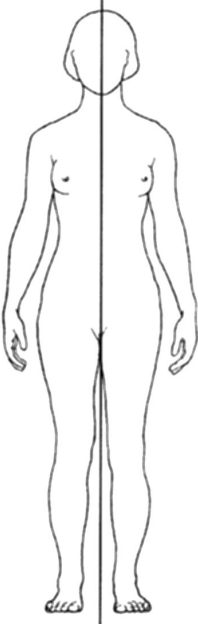



What do you hope to gain from this treatment?

Is there any other information you wish to share that may be relevant to this treatment?

PHYSICAL PAIN

Please ✓ relevant boxes and describe the pain in each area, years experienced, if pain is result of injury etc.

Neck & Shoulders	<input type="checkbox"/>	
Upper Back	<input type="checkbox"/>	
Lower Back	<input type="checkbox"/>	
Knee & Feet	<input type="checkbox"/>	
Elbows & Hands	<input type="checkbox"/>	
Any other pain	<input type="checkbox"/>	
Client Comments		

Please indicate any areas of pain or discomfort			
			
Anterior Right - Left	Posterior Left - Right	Lateral Left	Lateral Right

