Natural Health and Nutrition
Narelle Cooke
Accredited Clinical Naturopath and Nutritionist
BHSc (Nat). BAgrSc (hons). Adv Dip Nat. Adv Dip Nut. Adv Dip West Herb Med. MATMS.
425 Galston Rd, Dural, NSW, 2158
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NEW CLIENT PROFILE

How did you hear about me?

CONTACT DETAILS	
First name:	**Surname:**
Address:	
Phone 1:	**Phone 2:**
Email address:	
Name of emergency contact:	
Phone:	**Relationship to you:**

PERSONAL INFORMATION	
Age:	Date of birth:
Gender: ☐ Male ☐ Female	Marital status:
Height:	Weight:
Occupation:	Standard work hours/week:
Country of birth:	Nationality:

MEDICAL INFORMATION		
Doctor's name:	Contact number:	
Clinic address:		
Date of most recent blood tests:		
Do you give permission for me to contact your GP if necessary?	☐ Yes	☐ No

FAMILY HISTORY				
Are you adopted?			☐ Yes	☐ No
Relationship	**Age**	**Living / Deceased**	**Medical problems** (physical & mental health)	
Mother				
Father				
Brother(s)				
Sister(s)				
Other				

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HEALTH CONCERNS
Have you ever seen a Naturopath or Nutritionist before?
Were you satisfied with the results? If not, why?
What is your main health concern and primary reason for seeking a consultation today?
Please describe the onset of this health concern. What was going on in your life at the time it started?
Under what conditions do your current health problems get worse?
Under what conditions do your current health problems improve?
What treatments have you tried so far for this problem?
Please list any other health concerns that you would like addressed:
Please list any health problems that you have suffered from previously but which are currently not active:

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PAST SURGERY (List the type & approximate date)

CURRENT MEDICATIONS*	DAILY DOSE	HOW LONG TAKEN?

* Include prescription drugs, over-the-counter medicines, sleeping pills, laxatives, pain-killers etc.

HEALTH SUPPLEMENTS*	DAILY DOSE	HOW LONG TAKEN?

* Include all vitamins, minerals, herbal and nutritional preparations.

ALLERGIES / INTOLERANCES (includes drugs, supplements, foods, environmental)
Name of allergen and type of reaction

PHYSICAL ACTIVITY
Do you exercise? If Yes, how often, what kind of exercise & for how long? Do you have any injuries?

ENERGY
General energy levels out of 10? (0 – no energy and 10 boundless energy)
At what time of the day do you have the most energy and least energy?

SLEEP		
Do you sleep well at night?	☐ Yes	☐ No
Time to bed:	Time to sleep:	Time to wake:
Do you wake feeling refreshed?		

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WOMEN ONLY		
Are you currently pregnant?	☐ Yes	☐ No
If Yes, how many weeks advanced is the pregnancy?		
If 'No', are you trying to become pregnant?	☐ Yes	☐ No
Have you been pregnant before?	☐ Yes	☐ No
Any problems with prior pregnancies?		
Are you currently using any form of birth control?	☐ Yes	☐ No
If Yes, what type? (Pill, IUD, other)		

NUTRITIONAL INFORMATION		
Are you vegetarian or vegan? If so, for how long?		
Do you follow a special diet? i.e. gluten free / dairy free / low histamine / low salicylates		
Out of 7 days, how often do you dine out for:		
Breakfast?	Lunch?	Dinner?
What type of restaurants / food outlets do you typically go to?		
Do any religious practices or food philosophies affect your diet? If Yes, please explain:		
Do you have a history of the following? (Check all that apply)		
☐ Compulsive over eating	☐ Binge eating disorder	☐ Anorexia
☐ Bulimia	☐ Other	
If you have attempted to lose weight in the past, what diets have you tried?		
How much water do you drink a day?		
How many cups of black tea do you drink in a day? Sugar? Milk type?		
How many cups of coffee do you drink a day?		
Do you drink soft drink / energy drinks? How many in a day/week?		
How much alcohol do you drink each day/week? Type?		
Do you smoke cigarettes or use recreational drugs (current or previously)?		

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HEALTH SYSTEMS CHECK (Tick if you experience any of the following symptoms)

Head
☐ Headaches
☐ Migraines
☐ Dizziness
☐ Fainting

Eyes
☐ Eye strain
☐ Light sensitivity
☐ Blurred vision
☐ Watering
☐ Red eye
☐ Painful eye

Mouth, teeth & gums
☐ Toothache
☐ Lost or loose teeth
☐ Cold sores
☐ Ulcers
☐ Mercury fillings
☐ Bleeding gums
☐ Grinding teeth
☐Taste change

Digestive system
☐ Acidity / use of antacids
☐ Heartburn / reflux
☐ Ulcers
☐ Indigestion
☐ Nausea
☐ Sugar cravings
☐ Loss of taste
☐ Sweat has strong odour
☐ Bad breath
☐ Vomiting
☐ Bloating
☐ Constipation
☐ Diarrhoea
☐ Haemorrhoids
☐ Fissures
☐ Mucus/undigested food in stool
☐ Flatulence
☐ Excess belching
☐ History of antibiotic use
☐ History of laxative use
☐ Celiac, Crohn's, IBS, Colitis (circle)
☐ Kidney stones / gallstones (circle)

Skin, hair, scalp, nails
☐ Acne
☐ Eczema / Psoriasis (circle)
☐ Itchy / flaky skin
☐ Easy bruising
☐ Prone to rashes
☐ Hair loss
☐ Dandruff
☐ Excess sweating
☐ Finger nails chip/peel easily

Limbs / Joints
☐ Aching
☐ Muscle fatigue
☐ Muscle cramps / restless leg (circle)
☐ Tingling / Numbness
☐ Cold hands/feet
☐ Joint pains
☐ Arthritis / Gout
☐ Osteoporosis

Urinary system
☐ Excessive thirst
☐ Frequent toileting
☐ Burning
☐ Infections
☐ Restricted flow
☐ Change in urine colour
☐ Change in urine smell
☐ Blood in urine
☐ Incontinence

Nervous system
☐ Weakness
☐ Poor coordination
☐ Loss of balance
☐ Memory loss
☐ Difficulty concentrating
☐ Numbness
☐ Coldness

Emotional health
☐ Depression
☐ Anxiety / Excess worry
☐ Nightmares
☐ Insomnia
☐ Mood swings

Ear, nose, throat
☐ Deafness
☐ Ear noises
☐ Wax, ear aches
☐ Sinusitis
☐ Loss of sense of smell
☐ Blocked nose
☐ Hayfever
☐ Allergies
☐ Sneezing
☐ Swollen glands
☐ Recurrent colds/flu

Chest / Circulation
☐ Pains / Tightness
☐ Breathing difficulty
☐ Coughs
☐ Wheezing
☐ Palpitations
☐ Asthma
☐ Sleep apnoea
☐ Swollen ankles/feet
☐ High blood pressure
☐ High cholesterol

Female system
☐ Menstrual irregularities
☐ Cramps
☐ PMS
☐ Menopause
☐ Hot flushes
☐ Loss of libido
☐ Discharges / Infections
☐ Infertility
☐ Breast lumps / tenderness

Male system
☐ Erection concerns
☐ Lower back pain
☐ Sciatica
☐ Prostate problems
☐ Waking in night to urinate
☐ Change in urine stream – stopping/starting

Energy
☐ Daytime fatigue

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STRESS & EMOTIONAL HEALTH
Do you suffer from **anxiety, depression or any other diagnosed mood disorder**? Please detail:
What symptoms do you get?
How long has this been going on?
Was there something that started it? (only answer if comfortable to do so)
Is there anything that makes it better?
Is there anything that makes it worse?
Have you ever been on medication in the past for depression or other mood disorder?
Other comments:

Signed:	Date:
Name:	