*Thank you for choosing Lisa McDonald. Please complete the following and return with copies of tests results to Lisa McDonald:* [*admin@indigosagehealth.com.au*](mailto:patientintake@indigosagehealth.com.au)***48 hours prior to your appointment.***

**Your Details**

|  |  |  |
| --- | --- | --- |
| Name: |  |  |
|  | First Name | Last Name |
| Address: |  |  |
|  | Street | Suburb |
|  |  |  |
|  | State | Post Code |
|  |  |  |
| Date of Birth | Occupation | Marital Status |
|  |  |  |
| mobile | Home/work phone number | Email address |
|  |  |  |
| Skype Address | Private Health Fund | Number and Age of children (if applicable) |

How did you hear about us? (please indicate with a cross)

|  |  |
| --- | --- |
| Our website/google | Brochure/flyer |
| Social Media (please specify) | Referral ( please indicate name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Current Health Practitioners** (eg GP, Chiropractor, Psychologist)

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Your GPs Name | Clinic Address | Clinic phone number |
|  |  |  |
| Other Practitioner Name: | Clinic Address | Clinic phone number |

**Emergency Contact Details**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name | Relationship | Phone Number |

**Please indicate your current Health Concerns**

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |

**Please indicate your Current Health Goals:**

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |

**Current Medications and Supplements:**

**What medications are you currently taking?**

| *Medicine name* | *Dose and how often* | *How long have you taken this?* |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**What nutritional, herbal or other supplements are you currently taking?**

| *Item name and brand* | *Dose and how often* | *How long have you taken this?* |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Do you have any allergies or intolerances?** Please indicate and provide details of reaction

|  |  |  |
| --- | --- | --- |
| *Foods Allergies/Intolerances*  *e.g gluten, dairy, sulphur* | *Environmenal Allergies*  *e.g dustmite, mould* | *Medicine/Supplements/Herbs/other Allergies* |
|  |  |  |

**General Health History**

**What operations have you had?**

|  |  |  |
| --- | --- | --- |
| *What was it?* | *Date/when* | *Any issues?* |
|  |  |  |

**What major Illnesses or accidents have you had?**

|  |  |
| --- | --- |
| *Details* | *Date/when* |
|  |  |

**What childhood illnesses or health issues did you have?**

|  |  |
| --- | --- |
| *What* | *Approximate age/when* |
|  |  |

**Family History**

**Please indicate an X for conditions or illness you and/or members of your family have experienced**

**Please indicate an D for conditions if the family member passed away from this illness**

*Examples of conditions to indicate include: thyroid, cardiovascular, cholesterol, clotting or bleeding disorder, urinary or kidney issues, migraines, headaches, cancer (please indicate type), diabetes, depression, anxiety, bipolar disorder, OCD, weight issues, eating disorder, chronic fatigue, arthritis, allergies, crohns, eczema, liver problems, IBD, alzheimers, dementia, drug addiction, alcoholism, schizophrenia, asthma, blood pressures issue, Parkinsons, MS, Autism, ADD, Aspergers etc.*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Condition* | *You* | *Mother* | *Father* | *Sibling* | *Your child* | *Maternal G/Father* | *Maternal*  *G/Mothr* | *Paternal G/Fther* | *Paternal G/Mothr* |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**Systems Review**

*Please indicate with an ‘x’ if you experience any of the following symptoms*

|  | *In the past* | *Never* | *Sometimes* | *Frequently* | *How often? (3x per week, per month?, daily?)* |
| --- | --- | --- | --- | --- | --- |
| **Head, CNS** |  |  |  |  |  |
| Headaches |  |  |  |  |  |
| Migraine |  |  |  |  |  |
| Dizziness |  |  |  |  |  |
| Fainting |  |  |  |  |  |
| Memory Loss |  |  |  |  |  |
| Seizures |  |  |  |  |  |
| Convulsions |  |  |  |  |  |
| Loss of balance |  |  |  |  |  |
| Poor coordination |  |  |  |  |  |
| Numbness |  |  |  |  |  |
| Poor concentration |  |  |  |  |  |
| Coldness |  |  |  |  |  |
| **Eyes** |  |  |  |  |  |
| Light sensitivity |  |  |  |  |  |
| Blurred vision |  |  |  |  |  |
| Red eye |  |  |  |  |  |
| Puffy eye |  |  |  |  |  |
| Watery eye |  |  |  |  |  |
| Painful eye |  |  |  |  |  |
| Eyebrows thinning |  |  |  |  |  |
| **Ear, Nose, Throats** |  |  |  |  |  |
| Deafness |  |  |  |  |  |
| Ear noises |  |  |  |  |  |
| Waxy ears |  |  |  |  |  |
| Ear aches |  |  |  |  |  |
| Sinusitis |  |  |  |  |  |
| Loss of sense of smell |  |  |  |  |  |
| Blocked nose |  |  |  |  |  |
| Colds |  |  |  |  |  |
| Hayfever |  |  |  |  |  |
| Allergies |  |  |  |  |  |
| Sneezing |  |  |  |  |  |
| Swollen glands |  |  |  |  |  |
| Ear infections |  |  |  |  |  |
| Nose bleeds |  |  |  |  |  |
| Noise sensitivity |  |  |  |  |  |
| **Mouth, teeth, gums** |  |  |  |  |  |
| Toothache |  |  |  |  |  |
| Lost or loose teeth |  |  |  |  |  |
| Abscess |  |  |  |  |  |
| Ulcers |  |  |  |  |  |
| Mercury amalgams |  |  |  |  |  |
| Bleeding gums |  |  |  |  |  |
| Grinding teeth |  |  |  |  |  |
| Metallic taste in mouth |  |  |  |  |  |
| Cold sores |  |  |  |  |  |
| Cracks around mouth |  |  |  |  |  |
| Cant taste foods |  |  |  |  |  |
| Bad breath |  |  |  |  |  |
| **Skin, Hair, Nails** |  |  |  |  |  |
| Acne |  |  |  |  |  |
| Eczema |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |
| Hair loss |  |  |  |  |  |
| Warts |  |  |  |  |  |
| Excessive sweating |  |  |  |  |  |
| Slow to heal |  |  |  |  |  |
| Rashes |  |  |  |  |  |
| Itching |  |  |  |  |  |
| Redness |  |  |  |  |  |
| White spots on nails |  |  |  |  |  |
| Ridges on nails |  |  |  |  |  |
| Nails chip or peel easily |  |  |  |  |  |
| Sweat has a strong odour |  |  |  |  |  |
| Hair thinning |  |  |  |  |  |
| Facial hair (females) |  |  |  |  |  |
| **Mood and Emotional Health** |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Nightmares |  |  |  |  |  |
| Mood swings |  |  |  |  |  |
| Restlessness |  |  |  |  |  |
| Insomnia |  |  |  |  |  |
| Significant fears |  |  |  |  |  |
| Excess worry |  |  |  |  |  |
| **Musculoskeletal** |  |  |  |  |  |
| Aching |  |  |  |  |  |
| Tension |  |  |  |  |  |
| Arm Pain |  |  |  |  |  |
| Muscle pain |  |  |  |  |  |
| Tingling |  |  |  |  |  |
| Cold hands/feet |  |  |  |  |  |
| Joint pain |  |  |  |  |  |
| Numbness |  |  |  |  |  |
| Cramps |  |  |  |  |  |
| Stiffness |  |  |  |  |  |
| **Respiratory/Chest** |  |  |  |  |  |
| Post nasal drip |  |  |  |  |  |
| Chronic cough |  |  |  |  |  |
| Wheezing |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Shortness of breath |  |  |  |  |  |
| Chest pain |  |  |  |  |  |
| Chest tightness |  |  |  |  |  |
| Palpitations |  |  |  |  |  |
| **Digestive System** |  |  |  |  |  |
| Indigestion |  |  |  |  |  |
| Bleeding |  |  |  |  |  |
| Burping/ belching |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| Acidity |  |  |  |  |  |
| Sugar cravings |  |  |  |  |  |
| Carbohydrate cravings |  |  |  |  |  |
| Salty food cravings |  |  |  |  |  |
| Bad breath |  |  |  |  |  |
| Vomiting |  |  |  |  |  |
| Bloating |  |  |  |  |  |
| Constipation |  |  |  |  |  |
| Diarrhoea |  |  |  |  |  |
| Haemorrhoids |  |  |  |  |  |
| Fissures |  |  |  |  |  |
| Flatulence |  |  |  |  |  |
| Stomach pain |  |  |  |  |  |
| Abodominal pain |  |  |  |  |  |
| **Urinary system** |  |  |  |  |  |
| Frequent urination day or night |  |  |  |  |  |
| Frequently thirsty |  |  |  |  |  |
| Burning |  |  |  |  |  |
| Infection |  |  |  |  |  |
| Restricted flow |  |  |  |  |  |
| Blood in urine |  |  |  |  |  |
| Strong odour |  |  |  |  |  |
| Night urination |  |  |  |  |  |
| Lower back pain |  |  |  |  |  |
| Kidney stones |  |  |  |  |  |
| **Female System** |  |  |  |  |  |
| PMT/PMS |  |  |  |  |  |
| Hot flushes |  |  |  |  |  |
| Menopause |  |  |  |  |  |
| Menstrual irregularities |  |  |  |  |  |
| No menstruation |  |  |  |  |  |
| Loss of libido |  |  |  |  |  |
| Discharges |  |  |  |  |  |
| Infections |  |  |  |  |  |
| Difficulty conceiving |  |  |  |  |  |
| Breast lumps |  |  |  |  |  |
| Breast tenderness |  |  |  |  |  |
| Herpes |  |  |  |  |  |
| Other STD, warts, |  |  |  |  |  |
| Fibroids |  |  |  |  |  |
| Male System |  |  |  |  |  |
| Erection concerns |  |  |  |  |  |
| Sciatica |  |  |  |  |  |
| Prostate issues |  |  |  |  |  |
| Issues with urine stream stop/starting |  |  |  |  |  |
| Herpes |  |  |  |  |  |
| Other STD, warts |  |  |  |  |  |
| Lower back pain |  |  |  |  |  |
| Difficulty conceiving |  |  |  |  |  |
| Infections |  |  |  |  |  |
| Thrush |  |  |  |  |  |

**Bowels  
How often do you have a bowel movement?**

|  |
| --- |
|  |

**Do your stools float or sink?**

|  |
| --- |
|  |

**What colour are your stools? (green, yellow, brown, etc) ?**

|  |
| --- |
|  |

**Is there any blood, mucous, undigested food in the stool?**

|  |
| --- |
|  |

**Please provide details of any issues you have had with your bowels or digestion in the past:**

|  |
| --- |
|  |

**Female Reproductive System**

**What age did you get your first period?**

|  |
| --- |
|  |

**If you are not menstruating, what age did you go through menopause?**

|  |
| --- |
|  |

**If you are menstruating, is your cycle regular and how many days (e.g every 28 days)**

|  |
| --- |
|  |

**How many days to you bleed?**

|  |
| --- |
|  |

**What is the blood flow like? do you get any clots?**

|  |
| --- |
|  |

**Do you get any PMS ? (sore breasts, mood, pain, anxiety, cramps). Please provide details:**

|  |
| --- |
|  |

**What wart, viruses, thrush, herpes, infections do you get and how often?**

|  |
| --- |
|  |

**What contraception method do you use (if any)**

|  |
| --- |
|  |

**Could you be pregnant?**

|  |
| --- |
|  |

**How many pregnancies have you had?**

|  |
| --- |
|  |

**Have you had any issue trying to conceive?**

|  |
| --- |
|  |

**When was your last pap smear and have you had any abnormal pap smears currently or in the past?**

|  |
| --- |
|  |

**Blood Pressure**

**Is your blood pressure normally high or low. If you know your current blood pressure please also indicate:**

|  |
| --- |
|  |

**Mood and Cognition**

**Do you suffer from anxiety or panic attacks?**

|  |
| --- |
|  |

**What is your anxiety level? (0 – low and 10 high/panic attack)? please mark with an X:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
|  |  |  |  |  |  |  |  |  |  |

**What symptoms do you experience with your anxiety? (sweating, palpitations, phobias)**

|  |
| --- |
|  |

**When is it worse?**

|  |
| --- |
|  |

**When/what makes it better?**

|  |
| --- |
|  |

**What started your anxiety?**

|  |
| --- |
|  |

**How long have you experienced anxiety?**

|  |
| --- |
|  |

**Depression**

**How would you rate your mood? (0 – cant get out of bed to 10 extremely happy)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
|  |  |  |  |  |  |  |  |  |  |

**When is it worse?**

|  |
| --- |
|  |

**When is it better?**

|  |
| --- |
|  |

**What started your depression?**

|  |
| --- |
|  |

**How long have you experienced depression?**

|  |
| --- |
|  |

**Cognition**

**Do you get a foggy head?**

|  |
| --- |
|  |

**Do you feel like you cannot think properly?**

|  |
| --- |
|  |

**Do you forget words, difficulty expressing yourself?**

|  |
| --- |
|  |

**Have you taken medication in the past for your mood. If so, please indicate what you were prescribed and when:**

|  |
| --- |
|  |

**Lifestyle:**

**Energy Levels**

**How would you rate your energy levels? 1-10 (1 being lowest, 10 highest) Please mark with a ‘x’**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
|  |  |  |  |  |  |  |  |  |  |

**Do you experience any changes in energy levels during the day – if so, what time of day?**

|  |
| --- |
|  |

**What Is your best time of day and what is the worst?**

|  |
| --- |
|  |

**Have you had any periods of time of significant fatigue? If so, please provide details:**

|  |
| --- |
|  |

**Sleep**

**How many hours sleep to you have on average each night?**

|  |
| --- |
|  |

**Do you have any sleep problems? (eg getting to and/or maintaining sleep)?Please provide details:**

|  |
| --- |
|  |

**Do you wake refreshed? or have difficulty waking up? Please provide details:**

|  |
| --- |
|  |

**Weight**

**What is your current weight and height?**

|  |
| --- |
|  |

**Have you had any weight issues?. If so, please provide details:**

|  |
| --- |
|  |

**Have you gained or lost weight in a short period of time?**

|  |
| --- |
|  |

**Have you had a history of eating disorders? If yes, please provide details:**

|  |
| --- |
|  |

**Exercise**

**What exercise do you do and how long and often per week?(e.g weights, walk, run, swim, yoga)**

|  |
| --- |
|  |

**What do you do to relax? (e.g read, swim, sleep, yoga)**

|  |
| --- |
|  |

**Stress**

**How would you rate your current stress levels? 1-10 (1 being low and 10 being high). Please indicate with an X**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
|  |  |  |  |  |  |  |  |  |  |

**What experiences, if any, have you had that have been a major stress in your life such as death, divorce, bankruptcy? Please indicate:**

|  |
| --- |
|  |

**Diet**

**What beverages do you drink ? Please provide details:**

|  |  |  |
| --- | --- | --- |
| **Type** | **How Much** | **How Often** |
| Water |  |  |
| Alcohol (specify): |  |  |
| Tea/Coffee |  |  |
| Soft Drinks |  |  |
| Other: |  |  |

**What do you consume on a typical day? Please indicate below:**

|  |  |  |
| --- | --- | --- |
| *Breakfast* | *Lunch* | *Dinner* |
|  |  |  |
| *Mid Morning* | *Mid Afternoon* | *Snacks* |
|  |  |  |

**What food/drink cravings/aversions do you have?**

|  |  |
| --- | --- |
| **Cravings/Makes feel good** | **Aversions/Avoid/Don’t like/Makes feel yuck** |
|  |  |

**What diet restrictions do you have currently have or had in the past? (e.g vegetarian, paleo, gluten free). Please provide details:**

|  |
| --- |
|  |

**Environment:**

**Do you or have you every smoked? If yes, please provide details:**

|  |
| --- |
|  |

**Are you exposed to passive smoke or have you lived with a smoker in your lifetime?**

|  |
| --- |
|  |

**Do you currently or have you in the past used recreational drugs. If yes, please provide details:**

|  |
| --- |
|  |

**Have you ever lived or worked in a water damaged or damp building (flooding, damp, leaking, mould). If so, please provide details**:

|  |  |
| --- | --- |
| **When and how long for?** | **Location/details** |
|  |  |
|  |  |

**Have you ever been bitten by a tick or spider or experienced an unknown rash/bite? If yes, please provide details**

|  |  |  |
| --- | --- | --- |
| **What was it?** | **When did it occur** | **What did the rash/ skin reaction look like?** |
|  |  |  |
|  |  |  |

**Have you travelled overseas. If yes, please provide details:**

|  |  |  |
| --- | --- | --- |
| **Where** | **When** | **Any health issues?** |
|  |  |  |
|  |  |  |
|  |  |  |

**Have you been exposed during any of your current or past occupations, home or activities to chemicals, fumes, paints, plastics, gases? If yes, please provide details (e.g hairdresser, painter, dentist, farming, living in house whilst renovating):**

|  |
| --- |
|  |

**Thank you for completing this patient questionnaire**.

All information provided to Lisa McDonald will remain confidential. From time to time, to ensure optimum patient care, it may be necessary to discuss your health with your GP or other health practitioners. Please confirm your permission for your practitioner to contact your GP or other health provider by indicating an X in the appropriate box:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Please acknowledge and accept the following agreement and policies. These have been put in place as part of quality patient care to enable your practitioner to review your information prior to your appointment and the opportunity to offer your appointment time to another patient should you not be able to attend your appointment.

Please:

* Send your completed patient forms to the clinic 48 hours prior to your appointment
* Forward any relevant blood tests, stool tests, genetic report or other relevant health data to the clinic 48 hours prior to your appointment
* Please advise at least 24 hours prior to appointment time of any cancellation or rescheduling of appointment or 75% of the appointment fee may be charged.

Please sign below to confirm all information you have provided is true and correct and you accept the agreement and policies.

|  |  |
| --- | --- |
|  |  |
| **Name** | **Signature** |

Please send your completed form to [admin@indigosagehealth.com.au](mailto:admin@indigosagehealth.com.au) 48 hours prior to your appointment.

**Credit Card Details:** Your credit card details are required to book an initial consultation. This number will be saved on file and will only be used for the purpose of booking. It will not be charged unless you do not attend your appointment or cancel less than 24 hours prior to your appointment as per policy.

|  |  |
| --- | --- |
|  |  |
| **Name on Card** | **Credit card number:** |
|  |  |
| **Signature** | **Expiry Date** |