Macquarie Natural Health

Dubbo Clinic:
259 Brisbane St, Dubbo
Mudgee Clinic:
Mudgee Medical Centre, 145 Church St, Mudgee
Online Appointments:
via zoom or phone

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.

Title		Date of Birth	
First/Second Names		Surname	
Parent/ Guardian(for Child only)			
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.
_____
_____
_____
_____
_____

When was the last time you felt truly well?

_____

_____

_____

What do you expect from your consultation today?

_____

_____

_____

What do you think can help you?

_____

_____

_____

Child Only

Sleep pattern - please give details		
Caesar birth	Yes / No	
Breast Feed	Yes / No	Duration
Formula Feed	Details	
Symptom	**Yes/No**	**Age**
Reflux		
Colic		
Skin condition		
Urinary tract infection		
Ear infection		
Respiratory infection		
Oral thrush		
Hospitalisation		
Tunes out/Daydreams		
Complains of tummy discomfort		
Hyperactive		
Attention deficient		
Excessive flatulance		
Fatigues easily		
Poor short term memory		
Bad breath		
Irritable		
Sugar craving		
Poor motor skills		

Itching		
Bed wetting		
Hard to fall asleep		
Smelly stool(poo)		
Mood swings		
Aggressive		
Anxious		
Fungal Infection		
Pleae add any more details that you feel is relevant		

Medication history and details

Adults & Child

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

DIET

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

ADULT ONLY

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

FEMALE ONLY

Are you	**Tick - Yes/No**	**Details**
Menopausal		
Peri-menopausal		
Regular cycle		
Irregular cyce		
Do you use contraception		
Do you have children		
Are you pregnant		
Are you breastfeeding		
Number of pregnancies		
Please add any detailes you feel are relevant		

Family History				
Relative	**Age**	**Health Problem**	**Deceased Y/N**	
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				
Maternal Greandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Aunt/Uncle				
Aunt/Uncle				
Cousin				
Cousin				

MACQUARIE NATURAL HEALTH

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** _____

MACQUARIE NATURAL HEALTH

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:

MACQUARIE NATURAL HEALTH

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							