PATIENT CARD.

YOUR NAME_____

ADDRESS:

_____

POSTCODE:_____ MARITAL STATUS:_____NO. OF CHILDREN:_____

SEX: M /F_____ OCCUPATION:_____ BIRTHDATE:_____

PLACE OF BIRTH:_____HOME PHONE :_____

WORK PHONE:_____Email:_____

How did you hear about the Leanne's Natural Therapies Clinic ?_____

Would you like to be kept informed on changes to the clinic/ new treatments/ products etc ? Y / N

What is your major complaint ? _____

_____ _____ ____ _ _____

Any major accidents ?_____

Other minor complaints ?_____

How long have you had the condition?_____

LIST ANY MEDICATIONS: _____

Previous treatments _____-

Have you previously consulted with a 1. GP 2. Specialistt 3.beauty therapist 4. Naturopath

When did your condition first appear ? Age 1-15 years 16 -22 years old 30-50 years

Does any of the following aggravates your condition ? 1. Some foods 2. Weather wet or dry 3. Seasonal winter or summer 4.Temperature hot or cold 5. Morning or evening 6.Different types of clothing 7. Stress 8 .other_____

Is the condition getting worse ?_____How long has it been since you have felt well? _____

Do you have (or have had**) contact with any household or farm animals ?**_____

Please tick any of the following symptoms you may be experiencing

Emotional/ mental status	__ *angry*
__ anxiety	___suicidal tendency
__ changeable moods	___slow comprehension
__ crying moods	___sighing
__depressing moods	___screaming
__despairs getting well	___sadness
__difficult thoughts,dread ,nervousness	___passionate outbursts
__forgetful	___over sensitive
__fretful ___hallucinations ___indecisions	___ night terrors ___indifference ____fearful

Gastrointestinal -liver troubles	
___Nausea	_____vomiting
——gall bladder trouble or pain under right ribcage	_____feel sick when cooking oily, fatty foods
_____constipation or diarrhea	____flatulence
Other …..	

Gastro intestinal -Liver troubles		
___Nausea	_____vomiting	Bloating
——gall bladder trouble or pain under right ribcage	_____feel sick when cooking oily, fatty foods	Blood in faeces

Skin
___boils
___rashes
___dryness
___itching
___excema or dematitis
___psoriasis
___pigmentation Lighter
___pigmentation darker
___excess oiliness & acne
___skin type normal/ oily
___skin type dry
____Falling out of hair
_____tinea
_____foot odor unpleasant
_____nail with pits
____dandruff

Heart & Circulation
___always cold hands & feet
_____swelling of ankles
____dizziness
_____difficulty breathing after small effort
_____feeling cold and often a bit sick/uncomfortable
_____angina
Pain over heart
ringing in ears
Varicose veins
Slurred speech
dizziness
___palpitations
____high or low blood pressure

Sleep	**Eye conplaints**
_____ insomnia ie trouble getting or staying asleep	_____conjunctivitis.
___-Night Terrors	_____eye pain
____Restless sleep	_____Eye Inflammation
____Waking at 4am	

Muscular skeletal	
_____Pain in shoulders and neck area	____arthritic joints
___Pain in between shoulder blades	____other
____Lower back pain	____sciatica
_____Pain or numbness in hands or arms	_____twitching muscles

Nervous system
Numbness anywhere in body
Creeping paralysis
Ball sensation in throat

Respiratory	
____asthma	_____Inflammation of the eye
_____eye pain	_____conjunctivitis.
____sore throat or *strep throat*	- frequent colds /coughs
____asthma	_____hayfever/sinus
____sore throat or *strep throat*	difficult breathing

Females only
____hot flushes or night sweats
____irregular cycle
____menopausal symptoms
____PMT symptoms
Are you pregnant? Y /N_____

Males only
Difficult urination
Broken urine flow
Pain in legs
Painful urination
Erection difficulties
Low sex drive
Low sperm count
Swollen genitals or groin

Healthy History-Have you or a family member had any of the following conditions —— please tick

diabetes	psoriasis
epilepsy	polio
goiter or thyroid problem	cancer
M.S.	pneumonia
measles	pleurisy
mumps	emphysema
Tuberculosis	a history of miscarriage
maleria	allergies to foods
stroke	allergies environmental
typhoid or rheumatic fever	arthritis

How many glasses of water do you drink daily ?	**Do you smoke?** yes/ no	**Do you exercise regularly?**	
Are you exposed to any of the following Chemicals ?	oil based paints/laquers/ thinners insecticides/ herbicides	to hair dyes/ perming agents	chlorine in swimming pools or drinking water

Thank you for filling out this medical record .
Please signature that the above is correct.

Your signature here

_____

Please also bring with you any test results or medication that you may be taking at the moment and a list of medication that you have taken in the last 3 months that you are no longer taking .

Appointment times are valuable please notify me if you are unable to attend your scheduled time .

Call Leanne on 9730 4372
Email : therapist @healthclinic.net.au