Welcome to Optimum Health and your pathway to better health and wellbeing. We look forward to supporting your choice to restore what nature intended for you!

Please fill out the information below as best you can before your appointment. This will allow us to spend more time on you and your health during your first visit.

All information contained on this form and during your consultation will be treated with the utmost confidentiality and no information will be given to any persons without your direct consent.

I am pleased that you have chosen us to help you on your path to optimum health, I look forward to seeing you soon.

Jacinta

Appointment Date: …. / …. / …… Time: ……………………………………..

What to bring: ……………………………………………………………………………………………..

Personal Information

NAME					
PREFERRED NAME					
ADDRESS					
EMAIL					
NEWSLETTER	Would you like to receive our monthly newsletter? Y/N				
TELEPHONE (BH)			MOBILE		
DATE OF BIRTH					
EMERGENCY CONTACT	NAME: PHONE: RELATIONSHIP TO YOU:				
FAMILY DOCTOR					
DOCTOR ADDRESS					
WHO REFERRED YOU? Please circle	FACEBOOK	TWITTER	FRIEND	DOCTOR	OTHER
	OTHER DETAILS:				
CONCESSIONS	HEALTH CARE Y/N	PENSIONER Y/N	STUDENT Y/N		
PRIVATE HEALTH FUND	Y/N	NAME OF FUND:			
REMINDERS	Would you like a reminder via txt or email?				

What is/are the main health concerns that you have come to work with us on today?
Have your received prior treatment for this/these conditions? If yes, please details below:
Have you had any major health issues in the past ? If yes please detail below:

Do you have any of the following allergies or intolerances? Please tick for those with yes:					
Dairy		Tomatoes		Cigarettes (smoke)	
Soy Products		Artificial flavours		Dust mites	
Yeast		Artificial Colours		Wheat	
Alcohol		Grasses and Pollens		Gluten	
Jewellery		Bandaids		Sugar	
Cleaning Products		Fur		Starch	
Medicine: Please detail					
Other: Please detail					
Occupation/Type of work or daily routine: *What type of activity does your day mostly consist of… eg desk/computer/driving*					

Please name any current medicines and /or supplements that you are taking:			
NAME	DAILY DOSE	REASON FOR TAKING	DURATION OF USE

OTHER INFORMATION YOU WOULD LIKE TO PROVIDE:

What type of food do you normally eat?

Please note down the foods and beverages that you have consumed in the last 24 hours and observed adverse effects if any.

TIME	CONSUMED	ADVERSE EFFECTS
BREAKFAST		
MORNING TEA		
LUNCH		
AFTERNOON TEA		
DINNER		
SUPPER		
SNACKS OR BEVERAGES		

Please mark any symptoms that you are experiencing / have experienced

	x		x		x
Abdo pain		Eyes - sore, itchy, puffy, burning, watery		Nasal congestion	
ADD		Eyes - dark under		Nasal polyps	
ADHD		Eyelids swelling		Nausea	
anaemia (malabsorption)		Facial pressure		Neck Pain	
Anaphylactic shock		Facial swelling		Numbness	
Anxiety		Failure to thrive		Numbness - neck/shoulders/arms	
Apthous Stomatitis		Fatigue		Oedema	
Arrythmias		Iron deficiencies		Otitis Media	
Arthritis		Flaky skin		Palpitations	
Asthma		flatulence		Panic Attacks	
Asthma - delayed onset		flushing		Peptic Ulcers	
Asthma - Immediate		Food cravings		Post Nasal drip	
Athletes foot		Fungal nail infection		Psoriasis	
Atopic Eczema		Fungal skin infection		Rashes	
Autism		Gallstones		Rheumatoid Arthritis	
Auto Immune dx		Goosebumps - upper arm		Rheumatic pain	
Bed wetting		Haemorroids		Rhinitis	
Behavioral problems		Headaches		Ringing in the ears	
Blisters (itchy/watery)		Hives		Rosacea	
Bloating		Hyperactivity		Runny nose	
Blurred Vision		IBS		Sensitivity to chemicals	
Bone density↓		Indigestion		Sinusitis	
Bowel disorders		Infections - regular		Skin - changes colour/discoloration	
Breathlessness		Infertility		Sneezing	
Breathing difficulties		Insomnia/sleep disturbances		Shortness of Breath	
Bronchitis		Irritability		Sore throat	
Candida		Itchy - general		Stomach cramps	
Chest pains		Itchy nose		Stomach Pain/upset	
Chronic Fatigue		Itchy skin		Sweating - excess or lack	
Cognition disorders		Jock Itch		Swelling of eyelids/face/lip	
Colitis		Joint pain		swelling of hands/feet	
Concentration ↓		Joint swelling		Throat Infections	
Congestion		Learning problems		Thrush	
Constipation		Lethargy		Tinea	
Cough - persistant		Lip swelling		Tingling sensation	
		Memory ↓		Tinnitis	
Depression		Menstrual disorders		Urination - frequent/urgent	
Dermatitis		Mental confusion		UTI	
Diarrhoea		Migraine		Vaginal Infection	
Dizziness/co-ordination		Mineral def		Vaginal itching/discharge	
Dizzy/Head spins		Miscarriage		Vomiting	
Drowsiness		Mouth Swelling		Watery Eyes	
Ear ache		Mouth - Infections etc		Weakness - generalised	
Ear Infections		Mouth Ulcers		weight gain	
Eczema		Mouth - hot red rash		weight loss	
Epilepsy		MS		Wheezing	
		Muscular aches		Yeast Infection	