

**WELCOME** to the beginning of your health journey.Hannah is a Naturopath, Medical Herbalist, and Emotional Health Coach who helps people to activate their bodies innate ability to heal. She uses diet, nutrition, herbal medicine, emotional clearing and therapeutic clays to balance mood and hormones and improve overall health.

To enable me to assist you with your health goals, please take time to complete this form to the best of your ability, and send it back to admin@lotusholisticmedicine.com.au prior to your first appointment.   
**Directions:** Click in the grey boxes to either tick or write your response, save the document to your computer and then reply to this email, then attach your completed health assessment form to the email and press send). If you would prefer to print the form out and bring it in completed, your welcome to do this.

**Preparation for your appointment:**

* Please do not take any supplements for 2 meals before your first a subsequent health evaluations
* Bring with you all of your supplements (current and past)
* Bring with you all of your current medications
* Bring with you any relevant test results
* On appointment day please ensure you have drank plenty of water: 2 cups if in AM, 4 cups if in PM

**Strictly Confidential**

Naturopathic Health and Wellness Assessment Todays date:

Name:       Email:

Delivery Address:       Home Address:

Phone: (H)       (W):       (M):

Date of Birth:       Age:

Marital Status:       Spouse’s Name:

Children’s names:

Occupation:       Previous Occupation:

Weight:       Height:       Blood pressure:       Blood type:

Family Health History:  Cancer Diabetes Cardiovascular Other:

Ancestry (what part of the world are your ancestors from?):

Have you experienced Acupuncture or seen a Naturopath/Nutritionist before? Yes  No

How did you find out about us?:       Health fund:

**Chief Concerns:** Please list your main health concerns. Rank your complaints and severity on a scale of 1-10, 10 the most severe:

1st.       1-10

2nd.  1-10

3rd.       1-10

4th.       1-10

Have you tried therapies to help these issues in the past? What was successful and what was not?      

Please provide your top health events (up to ten) in a brief timeline of your personal health history from childhood including trauma (both physical and emotional); operations and major illness, the approximate age you were and what changes you experienced in your health      

**Medications:** Please list the medications and the daily dose you are currently taking.

1. Length of time taking

2.       Length of time taking

3.       Length of time taking

4.       Length of time taking

5.       Length of time taking

**Supplements:** Please list the supplements you are currently taking.

1.       Length of time taking

2.       Length of time taking

3.       Length of time taking

4.       Length of time taking

5.       Length of time taking

**Allergies:** Please list your allergies/sensitivities where applicable

Do you have any allergies or sensitivities e.g. peanuts, dust, gluten, penicillin, chemicals, dairy      

**General Health:** Please tick and fill in the boxes that apply to you.

How would you describe your energy level?  High  Low  Up & down

Does your energy change through the day? Please indicate average level of energy 1-10 (1 low 10 high)   
Morning (1-10)       Afternoon (1-10)       Evening (1-10)

How would you describe your sex drive?  High  Low  Up & down

I wake up in the morning feeling:  Refreshed  Tired  Exhausted

you consider yourself to have a sugar, caffeine, nicotine, sex, alcohol, drug or other addiction? Please specify

**Stress/Trauma:** Please list your main causes of stress

1.  2.

3.       4.

Rate your level of stress (1 being no stress at all 10 being an unbearable level of stress):

If above 6/10 what steps are you taking to reduce your stress level?

Please describe any psychological and/or emotional conditions you frequently experience:

I have suffered:  sexual abuse  emotional abuse  physical abuse  Other abuse:

Do you consider yourself to have a sugar, caffeine, nicotine, sex, alcohol, drug or other addiction? Please specify

**Energy Mood:** Please tick the boxes that apply to you.

I feel wired but tired  I feel restless + exhausted   
 I feel tired all day but can’t sleep at night  I get overstimulated by mild amounts of caffeine or sugar *Nrv/Exh*

I feel like my battery is flat  I feel mentally + physically exhausted *Ad/st*  
 Hard to get motivated start/complete tasks  I find it hard to get going in the morning

I feel downhearted and sad  I find it hard to get enthusiastic about anything   
 Its’s difficult to find initiative to do things  I see nothing in my future to be hopeful about *Infl/Md*

I feel anxious + worried a lot  I feel panicky or distressed often *nrv/anx/str* I find it difficult to relax  I feel nervous and tense often

I get easily irritated, frustrated or grumpy  Takes me a long time to wind down after an upset *hrm/st/lv*  
 I suffer from shoulder/neck pain/stiffness  I get impatient easily when held up in traffic, the lift, waiting etc

I worry excessively  I feel teary or cry easily *Emt*  
 I feel overwhelmed it’s too much to cope with  I find it difficult to make decisions and/or brood on past things

**Food Mood:** Please tick the boxes that apply to you

Sometimes I emotionally  Sometimes I binge on certain foods   
 I eat when I feel stressed  I tend to stop eating when I feel stressed  
 Sometimes I seek comfort in food  At times I find it hard to stop eating   
 At times I eat until my stomach hurts  Sometimes I can’t stop myself from eating   
 I’ve noticed eating makes me feel happy  I think about food a lot   
 No matter, how much I eat I don’t feel full  I often get random food cravings  
I eat when I feel:  feel sad  annoyed  [disappointed](https://personalexcellence.co/blog/disappointment/)  angry  [lonely](https://personalexcellence.co/blog/best-friends/)  empty  anxious  tired  bored

**Alcohol and other addictive substances:** Please fill in and tick the boxes that apply to you

Please indicate what substance you have an addiction to   
 When I feel emotional I tend to use/drink  I feel like I just can’t stop using/drinking  
 I use/drink when I feel stressed  Sometimes I can’t stop myself from using/drinking   
 Using/drinking provides me comfort  I think about drug/alcohol of choice a lot   
 Using/drinking makes me feel happy  When I feel stressed I tend to use/drink more   
  
I use/drink when I feel:   
 feel sad  annoyed  [disappointed](https://personalexcellence.co/blog/disappointment/)  angry  [lonely](https://personalexcellence.co/blog/best-friends/)  empty  anxious  tired  bored  Other  
Please write anything else you feel is relevant about the addiction here

**General Mood:** Please tick the boxes that apply to you. If some of these repeat from above please still tick them.

Over thinking  reprocessing of thoughts  Negative self-talk  Feel depressed   
 Anxiety with PMS  Winter blues  Worrying a lot  Second guess yourself often  
 Insomnia  TMJ pain/tightness  Compulsive  Cravings in the afternoon/evening

Low energy/fatigue  Low Focus  Lack of motivation  Foggy head   
 Reclusive don’t want to talk/see people  Hard to get out of bed in the morning

Low motivation  Low Drive  Apathetic  Hard to complete tasks  
 Addictions  Poor concentration  Poor Memory  General lack of pleasure

Anxiety  Impulsiveness  Hard to Relax  Inability to handle stress   
 Restless  Irritable  Tight shoulders when stressed

**Sleep:** Please tick the boxes that apply to you.

How would you describe your sleep:   
 Interrupted/light, wake often  I can’t get to sleep  Get to sleep easily, can’t stay a sleep  
 I wake unrefreshed  Hard to relax/switch off  Intense anxiety and/or panic upon waking I dream  I dream too much  I don’t dream much   
Please describe any reoccurring dreams How many hours per night?    
What time do you usually go to sleep?

**Digestion:** Please tick, circle and fill in what applies to you.

How often do you move your bowels (e.g. once daily or once every two days)

I feel satisfied after a bowel motion  My bowel motions sometimes/often float

My bowel motions are smelly  I experience gas/bloating

I experience nausea before bowel movement  My bowel motions tend to be on the looser side

My bowel motions tend to be banana shaped  My bowel motions tend to be hard/pebble like

I’m experiencing small or incomplete bowel motions  I experience pain before bowel movement

I feel nauseous after eating rich or fatty foods  I experience acid reflux/heart burn/indigestion, burp often

My stools have mucus in them  I use or have used laxatives

Hemorrhoids/rectal bleeding  I suspect parasites or have had parasites/worms before

The current colour of my stools are:   
 Whitish  Yellowish  Light brown  Brown   
 Dark brown  Black  Bloody Other:

**Urinary:** Please tick and fill in the boxes that apply to you.

My daily urinations are:  
 every 2-3 hours   Too frequent   Sense of urgency   Too small amount    
 Too large amount  Burning   Dribbling   Up several times at night Painful  Concentrated in colour  Slightly sweet smelling Other:   
How many times do you urinate per day?

**Dental:** Please tick and fill in the boxes that apply to you.

My last dental exam was:        I have 1 or more root canals  I have dental implants

I have silver fillings  I have dental pain  Bad breath

Receding gums   Bleeding gums  Mouth ulcers   Tooth pain 

I have had other dental procedures Other symptoms?

**Woman only:** Please tick and answer where appropriate

I am pregnant or breastfeeding  I am going through menopause

I have monthly periods Have you ever been on the contraceptive pill?

Current type of birth control used:       When and how long for?

Have you struggled with fertility/miscarriage?       Current or previous reproductive disorder?

How many children have you delivered?        I had an epidural

I have had an episiotomy or a C-section  I have had a hysterectomy

I experience hot flashes, night sweats I experience insomnia

I have cysts/fibroids/endometriosis/male pattern hair growth  I have difficulty losing weight

My libido has droppedOther:

**Cycle Details:** Please tick and answer where appropriate

Are your periods regular?       How many days is your cycle?

On average, how many days do you bleed for?       Date of last menstrual period:

The flow is:Flooding  Heavy  Medium  Light  Inconsistent/changes

The blood is:  Bright  Dark  Brown  Inconsistent/changes

How often do you experience clots in the blood?  Never  Occasionally  Usually  Always

How would you describe these clots?  Small and stringy  Small and lumpy  Large and lumpy

Do you experience spotting?       If yes, how often?

Do you use a moon cup, pads or tampons?       Do you experience PMS?

Do you experience painful periods / cramping?

**Men only:** Please tick the boxes that apply to you

I have experienced a drop in muscular strength  I have experienced a drop in sex drive

I have experienced a drop in libido  I have difficulty urinating and/or have an enlarged prostate

I have a low sperm count  I have problems getting or maintaining an erection

Premature ejaculation is a problem for me  Ejaculation is slow, inhibited or hard to achieve

Other:

**Symptoms:** Please describe any other symptoms not already mentioned

**Digestive:**

**Skin/Hair/Nails:**

**Lungs/Sinuses:**

**Reproductive/Hormonal:**

**Muscular/Skeletal:**

**Urinary/Kidney:**

**Cardiovascular/Circulation:**

**Nervous:**

**Immune:**

**Eyes/Ears:**

**Teeth:**

**Energy/Fatigue/Libido:**

**Mood/Emotional:**

**Mental:**

**Sleep:**

**Other:**

**Toxin Exposure:** Please tick and fill in the boxes that apply to you. (This is strictly confidential information)

I am an ex-smoker  I smoke (casually or daily) amount:

I drink less than 1 standard drink per day  I drink more than 2 standard drink per day

I regularly die my hair  I grew up on a farm

I have had exposure to heavy metals  I have had exposure to pesticides or other chemicals

I have used recreational drugs in the past?  I currently use recreational drugs?

Marijuana  Ecstasy  Cocaine  Methamphetamine  Heroin  Uppers  Downers Others

**Chemical Exposure:** Please indicate what brands you use

Perfume/cologne:       Hair Product:       Shampoo/conditioner:

Skin care:       Toothpaste:       Make-up:

Hair dye:       Nail polish remover:       Deodorant:

Shave cream:       Nail polish:       Insect repellent:

Dishwashing:       Air freshener:       Glass cleaner:

Laundry soaps:       Bleach:       General cleaners:

Pesticides:       Fertilisers:       Herbicides:

Please list any other major chemical exposure (from work, home decorating, garden, art, plastics):      

**Electromagnetic Exposure:** How many hours a day do you spend?…

Watching TV:       Computer use:       On landline phone:       Wearing a pager:         
Wearing a headset:       Wearing a watch:       Wearing hearing aids:       Travelling by vehicle:

How often have you flown in the last 3 years?

When you sleep, is your head within 3 meters of a plug-in clock, phone or any other electrical devices?      

**Surgeries/Injuries:** Please tick and fill in the details of all surgeries, operations, traumas, car accidents have you had.

I have had full body anesthesia for

I have surgical implants: breast implants  metal pins  plates  clamps Other      

I have had surgery for:  tonsil removal  wisdom teeth removal  rhinoplasty  tummy tuck   
 liposuction  mole removal Other

I have pierced ears or other body piercings?       I have tattoos?

Do you have any of the following scars?  circumcision  vasectomy  episiotomy scars  
Please describe any other scars on your body (major and minor ones)

**Exercise:** Please tick, circle or fill in the boxes that apply to you.

I exercise 3 times or more per week Types of exercise:

I want to lose weight My weight loss goal is

**Diet and eating habits:** Please tick and fill in the details where appropriate to you

Eating organic or spray free is a priority for me

How many litres of water do you drink per day?         
 I drink tap water  bottled water  Tank water Boar water  filtered water

How many caffeinated drinks do you drink per day?  Types of caffeinated drinks:

What are the other drinks you regularly consume?

Do you have a strong preference for or aversion to, any foods or drinks? (specify):

**Please keep a 3 day food diary before your appointment.** Write everything that you ate and drank – please be honest.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Day** | **Breakfast** | **snack** | **Lunch** | **snack** | **Dinner** | **Snack** |
| **1** | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time |
| **2** | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time |
| **3** | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time | Food & Drink  Time |

ConsentForm

At Lotus Holistic Medicine, Hannah uses gentle non-invasive techniques in order to determine the best approach to support your health and wellbeing using nutritional supplements, detoxification therapies, dietary, and lifestyle advice.   
  
During your initial consultation, your naturopath will review your history, clarify your health goals, and make sure that the services offered will match your expectations. Please take the time to fill out the important questionnaire contained within this package*. It is vital that you give us whole and truthful information especially concerning medications and any health conditions you may have, for example cardiovascular disease, diabetes etc*. The responses you provide will greatly assist your naturopath in understanding your health goals and expectations so that she can formulate an individualized wellness plan tailored to your needs. It is important that you understand the ultimate responsibility for your health care is your own, and that your naturopath is only here to support you in this. Her advice is not intended to replace the advice of your GP or health care provider but rather to assist the body to naturally heal its self. *\*It is not intended to diagnose, treat, cure, or prevent any disease.*

Client Consent

I understand that results cannot be guaranteed and I do not expect the practitioner to be able to anticipate and explain all risks and complications. I will rely on them to exercise judgment during the course of the procedures which they feel at that time is in my best interests, based on the facts that are known. I am also aware that there are some slight health risks in taking nutritional supplements. These include, but are not limited to:

* Potential allergic reactions to supplements or herbs
* Some aggravation of pre-existing symptoms
* The development of detoxification symptoms (headache, tiredness etc)

I understand that a record will be kept of the services provided to me, and that it will be kept confidential and will not be released to others unless so directed by myself unless the law requires it, I also understand that I may look at my health record at any time. I understand if I am seeing more than one practitioner at Live Moore I imply consent for them to share and discuss my file as deemed necessary by them.

With this knowledge, I voluntarily consent to assessment and advice from the practitioner in charge of my care for the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

Client Name: (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Guardian to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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