Health Appraisal Questionnaire

Chronic

Name: _____ **DOB:** _____

Address: _____

_____

Phone: _____ **Mob:** _____

Email: _____

Include the name and number of the following contacts if applicable:

GP'S Name: _____ **GP's Phone No:** _____

GP's Clinic Address: _____

Specialist's Name: _____ **Specialists Phone No:** _____

Specialists Clinic Address: _____

Your signature: _____

Thank you for choosing Shen Therapies to help you with your chronic complaint. Below is a list of questions that we need you to answer before you come and see us. This helps us know more about the reasons why you have your complaint or why you have been suffering from a particular disorder for so long. The answers are often simple and can be overlooked by the western model of medicine.

Could you please answer all the questions thoroughly and honestly. We need to know specific details to help. Could you then pop this into the mail and get it back to us **as soon as possible**. Please endeavour to answer all questions and list **all medications** including – the Pill, Vitamins, Herbs, antidepressants etc. Thank You and we look forward to seeing you soon!

All information is governed as strictly confidential and governed under the code of ethics.

GENERAL QUESTIONS

What is the main complaint you are coming to see us for? _____

_____

Do you have any medically diagnosed condition? YES ☐ NO ☐

Does your condition/s have a medical name? _____

How long have you had your complaint for? _____

What medical treatments have you had for this condition to date? _____

_____

What have the medical findings found with regards to this problem? _____

_____

Have you had any medical procedures/investigations done for this problem?

Please tick box and/or explain:

Laparoscopy ☐ Laparotomy ☐ Surgery (explain) ☐ Colonoscopy ☐

Ultrasound ☐ MRI ☐ CT Scan ☐ Endoscopy ☐

Other ☐ (Please Explain) *If you have had multiple procedures, please explain

_____

_____

Is there anything that makes your condition worse? _____

_____

Is there anything that makes your condition better? _____

Do you have any other medical conditions we should know about? _____

_____

Do you have any blood born diseases (HIV, Hep B, Hep C etc.) YES ☐ NO ☐

If yes, please explain _____

Do you have any other conditions that you need treated? _____

_____

Do you have any known allergies or intolerances? YES ☐ NO ☐

If yes, please explain _____

Have the allergies/intolerances been medically diagnosed? YES ☐ NO ☐

Do you suffer anaphylaxis? YES ☐ NO ☐

If yes, please explain _____

What other treatments or methods have you tried for help in this area? _____

_____

What expectations do you have on how long this complaint will take to be helped by our treatment? _____

In your opinion, how do you think that your complaint started and why do you think that it is still there? _____

_____

Are you on any medication at the moment? (Including any vitamins and herbal supplements)

_____

Are you allergic to any medications or products in medications, herbs, vitamins? (Please list)

_____

If you are allergic to certain medications or products, has this been medically diagnosed or recorded? _____

What happens if you take any of these products or medications? _____

_____

MENSTRUAL HISTORY (Females)

Are you getting a cycle at all? YES ☐ NO ☐

Is your cycle regular? YES ☐ NO ☐

How long is your cycle? (Eg-28-32days long) _____

How many days menstrual flow do you get? _____

Do you get any pain? YES ☐ NO ☐

Out of a scale of 1 to 10 what is you pain like (1 being the least and 10 being the worst) _____

Do you get any clotting or dark blood? YES ☐ NO ☐

Do you get any breast tenderness before the period? YES ☐ NO ☐

Do you get any digestive upset before or during the period? (Explain) _____

Do you get any changes to the bowel before or during the periods? (Explain) _____

_____

Do you get emotional before or during the period (explain) _____

Do you get any unexplained hair growth or dark hair? YES ☐ NO ☐

Do you get problems with acne or the skin relating to your cycle? YES ☐ NO ☐

Do you get erratic mood swings during your cycle? YES ☐ NO ☐

Do you get unexplained fluid retention? YES ☐ NO ☐

Do you suffer ovulation pain? YES ☐ NO ☐

Do you get mid-cycle or explained bleeding? YES ☐ NO ☐

Do you get headaches or migraines that relate to your cycle? YES ☐ NO ☐

Do you suffer low libido? YES ☐ NO ☐

Do you have or have you had a known STD? YES ☐ NO ☐

If YES, please explain _____

Contraception

Are you on a contraceptive? YES ☐ NO ☐

If yes, please list which one? _____

Do you have an IUD, Implant or any other devices? YES ☐ NO ☐

If yes, please list which one? _____

MALES

Do you suffer low libido? YES ☐ NO ☐

Do you suffer erectile dysfunction? YES ☐ NO ☐

Do you have problems with ejaculation YES ☐ NO ☐

Do you have frequent urination at night? YES ☐ NO ☐

If YES, then how many times per night are you getting up to urinate? _____

Do you have trouble with urination? YES ☐ NO ☐

SLEEP HISTORY (Everyone to fill out)

Do you sleep well? YES ☐ NO ☐

Do you suffer insomnia? YES ☐ NO ☐

Do you find it hard to get to sleep? YES ☐ NO ☐

Do you wake during the night? YES ☐ NO ☐

If YES, how many times are you waking YES ☐ NO ☐

Do you get frequent urination during the night? YES ☐ NO ☐

Do you find it hard to wake in the mornings? YES ☐ NO ☐

DIET

(Please fill out relevant information truthfully. If you eat lollies then write-Eat Lollies)

Please write a list of what you would eat in a typical day. Please fill it out in detail

(Can you also write down any drinks that you may have with your meal too?)

Breakfast _____

_____

Morning Tea _____

_____

Lunch _____

_____

Afternoon Tea _____

_____

Dinner _____

_____

Desserts _____

_____

Beverages

How many standard glasses of alcohol do you drink per week? _____

Do you drink alcohol on daily basis or more just on the weekend? _____

Do you binge drink? _____

Do you think that you may have a problem with alcohol consumption? _____

Has anyone commented that you may have an issue with alcohol intake? _____

Do you need to have alcohol on a regular basis? _____

Can you go without alcohol or do feel the need is too strong to have it? _____

How many cups of tea or coffee do you drink per day? _____

Do you drink caffeinated soft drinks regularly? _____ (List which ones) _____

How many soft drinks would you have in a week?

Do you drink soft drinks or sugar based drinks (including juice) on a daily basis? (Explain) _____

_____

Appetite/ Digestion

How is your appetite? (High, Low etc.) _____

Does your appetite change with your menstrual cycle? ***(Females)*** _____

How is your digestion? _____

Do you notice any foods that affect your digestion? (Explain and list) _____

_____

Do you get any sugar cravings? _____

Do you eat chocolate or sugars on a regular basis? _____

Do you get any bloating, heartburn, wind, nausea or burping? (Explain) _____

_____

If so how often does this occur? _____

Do you skip meals on a regular basis? _____

Bowels

Do your bowels move on a daily basis (Explain)? _____

How many times per day do you move your bowels? _____

Are your motions loose, hard, alternating or normal? (Explain) _____

Do you suffer from either loose bowels or constipation often? _____

Are your bowels affected by stress? _____

Do you notice any foods that affect your bowels? _____

Do you have a diagnosed digestive or bowel condition? (Explain) _____

Miscellaneous

Do you smoke? (Includes social smoking) YES ☐ NO ☐

If YES, explain how many per day or occasion? _____

Do you smoke cannabis or use any other recreation drug? YES ☐ NO ☐

If YES, explain which drugs and how often _____

_____

Do you suffer any headaches or migraines? YES ☐ NO ☐

Please explain the location of these headaches/migraines? _____

How often do you get these headaches/migraines? _____

What treatment have you had for these headaches/migraines? _____

_____

Miscellaneous (Continued)

Do you suffer any back pain? YES ☐ NO ☐

Do you have a diagnosed back/disc condition? YES ☐ NO ☐

If YES, please explain _____

How long have you had the back issue for? _____

What treatment have you had for the back issue to date? (please list all) _____

_____

Do you suffer stiff neck or sore shoulders? YES ☐ NO ☐

Do you have a diagnosed neck/disc condition? YES ☐ NO ☐

Have you ever suffered whiplash? YES ☐ NO ☐

Do you have a diagnosed shoulder condition? YES ☐ NO ☐

If YES to any of the above, please explain _____

_____

How long have you had the neck or shoulder issue for?

What treatment have you had for the neck or shoulder issue to date? _____

_____

Do you have any known skin conditions? YES ☐ NO ☐

If YES, Please Explain _____

How long have you had the skin condition for? _____

Is there anything that makes it worse? _____

Is there anything that seems to make it better? _____

What treatments have you had for this condition to date? _____

_____

Do you have any symptoms or conditions not listed above? (Please explain) _____

_____

_____

Please list all drugs, medications, herbal supplements and vitamins if not listed before

_____

_____

_____