Megan Clarke
Adv. Dip Herb. Med. Nut. Dip
Medical Herbalist
Nutritionist
Iridologist
Haemaview Practitioner
(Live Blood Analysis)

THE Natural Apothecary
HERBAL DISPENSARY

Personal Details

Date: _____

Name: _____ Male/Female

Address: _____

_____ Postcode: _____

Home Ph: _____ Mobile: _____

Work Ph: _____ Private Health Insurance: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Occupation (current & previous): _____

Who do you live with? _____

Do you have any children? _____

Hobbies/Activities: _____

Allergies (medication, food, other): _____

Current Health Practitioners (Doctor, Gynaecologist, Osteopath, etc) – please give name and contact details:

_____

_____

Referral

How did you hear about us (friend, family, Health Practitioner, Doctor, internet search, other)?
We like to acknowledge those that refer their friends and family. Please let us know who they were.

_____

Appointment Confirmation

Please provide the best email address for appointment reminders:

_____

Cancellation Policy

Our goal is to provide quality health care in a timely manner. As such, we have had to implement an appointment cancellation policy. This policy enables us to better utilise available appointments for our patients in need of our services. Please be courteous and notify us by phone or email if you are unable to attend an appointment at least 2 working days prior to your scheduled appointment. We will then be able to allocate this time to someone on our waiting list. Please note that if you miss an appointment or reschedule inside the 48 hours a consultation fee may be charged.

Privacy Clearance and Consent

I understand that Megan Clarke is a Herbalist and Nutritionist and not a Medical Doctor.

I give my permission for my health history to be kept on file for the purpose of naturopathic treatment. I understand that all information within my file will be kept confidential at all times.

I give Megan Clarke permission to access past and current medical records from other health professionals/testing services as appropriate. Furthermore, I give Megan Clarke permission to release relevant details regarding my health to my other health professionals when appropriate. I am aware that she will inform me if this is to occur.

I give permission for _____ (please insert name) to collect naturopathic medicines on my behalf when required.

All information given within this questionnaire is to the best of my ability and is a true and accurate representation of my health.

Signature: _____

e: megan@naturalapothecary.com.au
Ph: 0402 330 022

Current Health Concerns

Please outline the health issues you wish to address during the course of your naturopathic treatment. Please include key symptoms you are currently experiencing.

Main Health Concern 1: _____

_____

_____

_____

_____

Main Health Concern 2: _____

_____

_____

_____

_____

Main Health Concern 3: _____

_____

_____

_____

_____

Current Medications

Please list any medications/supplements you are taking (including dosage, brand and quantity):

_____

_____

_____

_____

Recent Tests

Please outline any recent tests you have undertaken and attach a copy of the results to this questionnaire.

_____

_____

_____

_____

General Medical History

Details of operations: _____

_____

_____

_____

Details of major illnesses: _____

_____

_____

_____

Details of childhood illnesses: _____

_____

_____

_____

Lifestyle and Environmental

How would you rate your energy levels? Low / Medium / High
Do you or have you smoked cigarettes? Yes / No
If yes, please give details:

_____

Are you exposed to passive smoke? Yes / No

_____

Do you or have you used recreational drugs? Yes / No
If yes, please give details:

_____

Do you drink alcohol? Yes / No
If yes, please give details:

_____

Have you experienced a major stress such as death, divorce, bankruptcy or other that has affected your health?
Yes / No
If yes, please give details:

_____

Does your job involve frequent contact to chemicals, plastics, fumes, glues, gases, colouring/perming agents?
Yes / No
If yes, please give details:

_____

General Health

Please tick the following symptoms where appropriate:

GASTROINTESTINAL
- ☐ Heartburn/Reflux
- ☐ Indigestion
- ☐ Bloating
- ☐ Flatulence
- ☐ Bad breath

Bowels / Stool Health:
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Blood
- ☐ Mucous
- ☐ Anal itching
- ☐ Laxative use
- ☐ Worms/parasites

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Asthma
- ☐ Nasal congestion
- ☐ Post nasal drip
- ☐ Hay fever
- ☐ Sinus congestion
- ☐ Allergies:
  - ☐ Airborne
  - ☐ Food/Beverage
  - ☐ Chemical

CARDIOVASCULAR
- ☐ Angina
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Swollen ankles
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Heart attack
- ☐ Heart murmur

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Migraines
- ☐ Poor concentration
- ☐ Confusion
- ☐ Poor memory
- ☐ Loss of sensation
- ☐ Poor coordination
- ☐ Pins and needles
- ☐ Tinnitus
- ☐ Fatigue
- ☐ Learning difficulties
- ☐ ADD/ADHD

FEMALE REPRODUCTIVE
- ☐ Fibroids
- ☐ Endometriosis
- ☐ PCOS or cysts
- ☐ STD
- ☐ Pap smear abnormalities
- ☐ Breast pain or issues
- ☐ Infertility

MENSTRUAL HEALTH
- ☐ Menstruating
- ☐ Irregular cycle
- ☐ Menstrual pain
- ☐ PMS Ovulation pain
- ☐ Spotting
- ☐ Clots

MENOPAUSE
- ☐ Headache or migraine
- ☐ Mood changes
- ☐ Hot flushes
- ☐ Bone problems

MALE REPRODUCTIVE
- ☐ STD
- ☐ Balding
- ☐ Varicocele or cysts
- ☐ Infertility
- ☐ Hernia
- ☐ Erectile dysfunction
- ☐ Impotence
- ☐ Testicular injury
- ☐ Vasectomy

ENDOCRINE
- ☐ Appetite irregularities
- ☐ Weight gain
- ☐ Weight loss
- ☐ Night sweats
- ☐ Blood sugar problems
- ☐ Thyroid problems
  - ☐ Over-Active
  - ☐ Under-Active

HAEMATOLOGY
- ☐ Anaemia
  - ☐ Iron
  - ☐ B12
  - ☐ Folic Acid
- ☐ Haemochromatosis
- ☐ Easy bruising
- ☐ Frequent nose bleeds

SKIN
- ☐ Dry
- ☐ Oily
- ☐ Eczema/Dermatitis
- ☐ Psoriasis
- ☐ Poor wound healing
- ☐ Excessive sweating
- ☐ Rash or irritation
- ☐ Offensive body odour
- ☐ Acne

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Joint pain/stiffness
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Neck problems
- ☐ Muscle cramps

LIVER / GALL BLADDER
- ☐ Hepatitis
- ☐ Gall Bladder removal
- ☐ Difficulty digesting fats
- ☐ Poor alcohol tolerance

URINARY TRACT
- ☐ Urinary tract infections
- ☐ Discomfort passing urine
- ☐ Kidney pain
- ☐ Decreased flow
- ☐ Passing urine at night
- ☐ Increased frequency

IMMUNE
- ☐ Frequent colds & flu
- ☐ Swollen glands
- ☐ Thrush or Candida
- ☐ Cancer
- ☐ HIV
- ☐ Glandular fever
- ☐ Auto immune condition

SLEEP
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Nightmares
- ☐ Vivid dreams
- ☐ Wake tired
- ☐ Bed wetting
- ☐ Snore

HAIR
- ☐ Poor quality
- ☐ Increased loss
- ☐ Dandruff
- ☐ Dry
- ☐ Oily

NAILS
- ☐ Soft
- ☐ Splitting
- ☐ White spots
- ☐ Flaking
- ☐ Brittle

EMOTIONAL
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Anger
- ☐ Phobias
- ☐ Mood swings
- ☐ Irritable
- ☐ Prolonged stress

ENVIRONMENTAL
- ☐ Microwave usage
- ☐ Computer usage
- ☐ Mobile phone usage
- ☐ Live near flight path
- ☐ Chemical product usage
- ☐ Frequent airplane travel
- ☐ Multiple X-rays
- ☐ Heavy metal exposure

Family History

1. Place a tick ☑ in the appropriate box if a family member suffers from this problem.
2. Place a cross ☒ in the appropriate box if a family member has died from this illness and the age they passed away.

Condition	Mother	Father	Siblings	Maternal G'Mother	Maternal G'Father	Paternal G'Mother	Paternal G'Father
1.	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐	☐	☐

Thank you

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