Karlie McKeand
Naturopathy Nutrition Herbal Medicine

CLIENT FORM

(Please Print)

Name				Date	/ /
Address				Post code	
Home Phone		Mobile		Sex	F M
Birth date	/ /	Occupation			
Email address				Health Fund	
How did you hear about Karlie McKeand Naturopath?					
Have you been referred? Please provide their name-					

Health Information		
Briefly describe your current health issues?		
What would you like to achieve from our time together?		
Briefly describe any hospitalisations, accidents, broken bones (no matter how long ago)		
If you answer yes to any of these questions, please provide more information.		
Have you ever had any fits, faints or funny turns?	Yes ☐ No ☐	
Do you have any allergies?	Yes ☐ No ☐	
Do you have any food intolerances?	Yes ☐ No ☐	
Have you had any vaccinations?	Yes ☐ No ☐	

Do you have any varicose veins?	Yes ☐ No ☐	
Are you pregnant?	Yes ☐ No ☐	
Do you have any communicable diseases?	Yes ☐ No ☐	

What changes have you had recently in your weight, home or work life, relationships?

Please list your current medications (including supplements) and dosages

What do you do for exercise, hobbies and relaxation?

How would you rate your current stress level?
LOW MEDIUM HIGH

What are your main stress factors?

How do you rate your… (between 1-10 10= Excellent)

Energy / Vitality -

Health -

Fitness -

How long do you feel it will take to achieve your health goals?

General Symptoms Review (Tick all that apply)					
SKIN		CARDIAC		NEUROLOGICAL	
Rashes	☐	Hypertension	☐	Dizziness	☐
Lumps	☐	Pain	☐	Faints	☐
Soreness	☐	Cold Extremities	☐	Numbness	☐
Itchy	☐	Shortness of Breath	☐	Tingling	☐
Psoriasis	☐	Palpitations	☐		
Eczema	☐			MUSCULOSKELETAL	
Lesions	☐	GASTROINTESTINAL		Pain	☐
Warts	☐	Heartburn	☐	Limited Range	☐
		Burping	☐	Stiffness	☐
HEAD		Nausea	☐	Achy	☐
Headaches	☐	Appetite Increase / Decrease	☐	Injury	☐
Injury	☐	Diarrhoea	☐		
Migraine	☐	Bloating	☐		
Hair Loss	☐	Constipation	☐		
EYES		URINARY		RESPIRATORY	
Pain	☐	Night time urination	☐	Cough	
Redness	☐	Infection(s)	☐	Mucus	
Double Vision	☐	Burning / Stinging	☐	Wheezing	
Visual Disturbances	☐	Sensation of Urination	☐	Chest pain	
Watery	☐	Urgency	☐		
Itchy	☐	Dribbling	☐		
		Pain	☐		
EAR, NOSE & THROAT		Incomplete	☐		
Earache	☐			OTHER SYMPTOMS Not listed here that you are concerned about	
Decreased hearing	☐	REPRODUCTIVE			
Tinnitus	☐	Pain	☐		
Discharge	☐	Premenstrual Tension	☐		
Hayfever	☐	Menopause	☐		
Sinusitis	☐	Prostrate Problems	☐		
Infection	☐	Breast Lumps	☐		
Tonsillitis	☐	Breast Tenderness	☐		
		Pregnant	☐		

Family Medical History				
Paternal		Maternal		Siblings
Father	Grandfather	Mother	Grandfather	
	Grandmother		Grandmother	

Diet
Please describe your meals and beverages on a normal day BREAKFAST_____ _____ MORNING TEA_____ _____ LUNCH_____ _____ AFTERNOON TEA_____ _____ DINNER_____ _____ DESSERT_____ _____ Do you crave? Sugar ☐ Salt ☐ Savoury ☐ Fats ☐

Please record how much you have daily/weekly of these fluids

Water_____

Coffee_____

Tea_____

Alcohol_____

Soft Drink_____

Milk_____

Juice_____

CANCELLATION POLICY

If you need to cancel or reschedule an appointment, we ask that you provide 24 hours notice so we can fill your allocated appointment time with someone else requiring an appointment. Cancellations at short notice will incur a $50 cancellation fee and no shows will be required to pay a $50 deposit for future appointments.

The above information is true to the best of my knowledge. I understand and agree to Karlie McKeand Naturopath's Cancellation Policy.

_____ _____

Patient (Parent / Guardian) signature Date