

ONLINE HEALTH ASSESSMENT FORM

Preamble

So that we can give a complete and thorough analysis, please complete the form below in as much detail as possible. All information is strictly confidential.

Once the form is complete, SAVE AS with your name as the file name and email back to us at consult@naturalway.co.za. You will receive a confirmation email that it has been received.

NAME: _____

ADDRESS: _____

TEL #s _____ (w) _____ (h)

MOBILE NUMBER: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

OCCUPATION: _____

Name and relation of responsible person in case of a child:

TEL #s _____ (w) _____ (h)

MOBILE NUMBER: _____

HEALTH HISTORY:

(Starting from the day you were born including the type of birth, breast/bottle fed, allergies, illnesses like measles etc. – Detailed)

HOSPITALISATION or CLINICS: *(please give dates and why you were hospitalised including childbirth type e.g. natural/caesarean)*

WHAT MEDICATION WERE YOU ON IN THE PAST: *incl. dosages, recreational drugs e.g. marijuana, cocaine etc. any sports drugs and how long you have been on the drug.*

WHAT MEDICATION ARE YOU ON PRESENTLY: *incl. dosages, recreational drugs e.g. marijuana cocaine etc., any sports drugs and how long on drug.*

PRESCRIBED:

NON-PRESCRIPTION:

SUPPLEMENTS (vitamins etc.):

A MEMBER OF YOUR FAMILY HAS HAD...: (say who e.g. grandfather, aunt etc.)

Heart trouble

Parkinson's Disease

High Blood Pressure

Liver disorder

Arthritis (+ where)

Diabetes(+ age diagnosed.)

Cancer (+ where)

Other

CURRENTLY:

YOU HAVE RECEIVED THE FOLLOWING DIAGNOSIS AND/OR YOUR PRESENT CHIEF COMPLAINT(S) IS:

If diagnosed, then by whom:

ARE YOU PRESENTLY UNDER TREATMENT? IF SO, FOR WHAT PURPOSE AND BY WHOM?

GENERAL:

Type of glasses you wear: _____

Your hearing is.. _____

Name any foods, medicines and/or other substances that you are allergic to presently:

How was this allergy identified?

How would you describe your appetite?

Do you have a heavy feeling after eating?

Is there any bloating?

Do you emit gas at times!? _____

How often do you have a bowel movement (BM)? _____

Do you ever experience diarrhoea? If so, how often

Are you ever constipated? _____

How many colds per year do you have? _____

Do you have any respiratory trouble? _____

Do you suffer from sinusitis? _____

Do you enjoy your work? _____

Can you take a rest period at work? _____

I am somewhat..

Nervous

Irritable

Depressed

Stressed

I am worried about.. _____

Do you have difficulty in going to sleep at night? _____

How often do you get up during the night? _____

I arise at _____ and retire at _____

Do you have bad breath? _____

Do you spit up a lot of mucous, especially in the morning? _____

Do you tire easily during the day? _____

If you are a woman, do you menstruate regularly or what is your cycle like? _____

How long do you menstruate for? _____

Describe your menstrual flow (heavy, scant, other): _____

Describe any discomfort(s) during or before a period: _____

What type of contraception do you use, if any? _____

Do you suffer from any discharge or thrush? _____

Do you sometimes observe swelling:

in your eyelids _____ fingers _____

ankles _____ other places _____

Are you a social person and do you enjoy being with other people?

Do you have any hobbies/interests that you are pursuing at the moment?

Do you smoke? No Never smoked

Yes, at present

Stopped _____ years/months ago.

If "yes", how many do you smoke per day? cigarettes _____ cigars _____ other _____

and for how many years did you or have you smoked for? _____

If you smoke at present, have you ever tried to give up smoking?

WHAT EXERCISE ARE YOU DOING, IF ANY?

HOW OFTEN DO YOU GET INTO THE SUN? _____

PREVIOUS AND PRESENT DIET

Please state exactly what you eat and drink. Give specific details like lettuce, cucumber, tomato (not just salad) or Kraft Italian Dressing (not just salad dressing) or Diet Sprite, Tab, Coke (not just cold drink) or white commercial bread (not just bread) etc. Please also state the times that you eat and include sweets/snacks etc.

My present diet is as follows:

List everything you eat and drink at these various times

Wake up:

Breakfast:

Midmorning:

Lunch:

Midafternoon:

Supper:

After dinner snacks or drinks

Do you get up at night to eat or drink?

If so what do you eat or drink?

Please list your previous diet if it has changed.

This is important as your previous diet may have been better or worse than your present diet and this may impact on your health.

For how long (months or years) did you follow

previous diet _____ present diet _____

If you use any condiments e.g. seasonings etc., please list them.

If you use any frozen, tinned and/or packaged foods, please list them.

How much tea and/or coffee do you consume a day?

Previously - tea _____ coffee _____

Presently - tea _____ coffee _____

How much alcohol do you consume? (stipulate beer, brandy etc.)

Is there any other information that you feel I should know?