Patient Information

Alchemy Wellness Centre
38 Granuaille Rd.
Bangalow, NSW 2479
(02) 6687 1276

Patient Name: _____ Date of Birth: _____

Sex: F/M Occupation: _____ Height: _____ Weight: _____

Street Address: _____ City: _____ State: _____ Post Code: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Private Health Fund: _____

Emergency Contact:

Name: _____ Phone No: _____

How did you hear about us?: _____

Main reason for your visit? _____

_____

Do you have any known Allergies or Medical Conditions? No /Yes _____

_____ (Please give details)

Do you have a tendency to bleed or bruise easily? No/Yes

Please list any relevant family medical history: _____

_____

Female Patients: Are you pregnant or is there a possibility of being pregnant? No/Yes

Menstruation: Age at Menarche: _____ Date of last period? _____ Day in Cycle _____

(Referrals to your family and friends are always greatly appreciated!)

I understand by signing this form that the information provided is true to the best of my knowledge. Changes to the above should be advised upon future visits. I consent to receive proposed treatments by the attending practitioner subsequent to discussing the benefit of that to my health. I understand that all bills are to be settled at the conclusion of each visit. Also, cancelation of an appointment within 24 hours will incur a 100% cancelation fee.

Patient Signature: _____ **Date:** _____

Health History Questionnaire

Major Complaint(s):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

How do these conditions affect your daily activities?: _____

_____

_____

_____

Primary Physician: _____

Other physicians/therapists: _____

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

Supplements (vitamins, herbs, minerals, etc.): _____

_____

_____

Health History Questionnaire

List all hospital stays, surgeries, or major illnesses that you have had since birth	Year Occurred

	Test	Year	Test Results
☐	Physical	_____	_____
☐	Cholesterol	_____	_____
☐	Prostate	_____	_____
☐	Mammogram	_____	_____
☐	Pap Smear	_____	_____
☐	Blood	_____	_____
☐	HIV/STD	_____	_____

Please check if you have or had any of the following conditions

☐ Diabetes	☐ Syphilis	☐ Mumps	☐ Jaundice
☐ Heart Disease	☐ CVA (Stroke)	☐ Rheumatic Fever	☐ Hepatitis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Vein Condition
☐ Allergies	☐ Gonorrhea	☐ Bleeding Tendency	☐ Tuberculosis
☐ Meningitis	☐ Measles	☐ High Blood Pressure	☐ Chicken Pox
☐ Epilepsy	☐ HIV	☐ Nervous Disorder	☐ Polio
☐ Paralysis	☐ High Fever	☐ Glandular Fever	☐ Migraines
☐ Glaucoma	☐ Cancer	☐ Multiple Sclerosis	☐ Anxiety

Health History Questionnaire

Please check all the symptoms that you are currently experiencing or have experienced in the last 6 months.

Pain

What makes the pain better?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other: _____

What makes the pain worse?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Describe Your General Pain

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Lung & Kidney Function (Overall Temperature)

- ☐ Shortness of breath
- ☐ General weakness
- ☐ Daily chronic fatigue & malaise
- ☐ Low energy
- ☐ Difficulty keeping eyes open (daytime)
- ☐ Easily catch colds
- ☐ Feel worse after exercise

TOTAL BOXES CHECKED: _____

Liver, Spleen, Heart Function

- ☐ Dizziness
- ☐ See floating black spots

TOTAL BOXES CHECKED: _____

Heart Function

- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Trouble falling and/or staying asleep

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Pancreas/Spleen Function

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Worry
- ☐ Gurgling noise in stomach
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Prolapsed organs: _____
- ☐ Overthinking

TOTAL BOXES CHECKED: _____

Small/Large Intestine Function

- ☐ Loose stools
- ☐ Constipated
- ☐ Incomplete stools
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

TOTAL BOXES CHECKED: _____

Lung Function

- ☐ Nasal discharge (color: _____)
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Allergies (type: _____)
- ☐ Alternation of chills/fever
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Sneezing
- ☐ Headache (location: _____)
- ☐ Overall achy feeling in body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (packs per day: _____)
- ☐ Sadness
- ☐ Melancholy

TOTAL BOXES CHECKED: _____

Stomach Function

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad Breath
- ☐ Canker sores (mouth)
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach pain
- ☐ Vomiting

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Dampness Trapped in the Body

- ☐ Bodily sensation of heaviness
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

TOTAL BOXES CHECKED: _____

Liver Function (Eyes)

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near sighted
- ☐ Far sighted

TOTAL BOXES CHECKED: _____

Liver, Gall Bladder Function

- ☐ Alternating diarrhea & constipation
- ☐ Chest pain
- ☐ Tight sensation in chest
- ☐ Bitter taste in mouth
- ☐ Anger easily
- ☐ Depression
- ☐ Frustration
- ☐ Irritability
- ☐ Skin rashes
- ☐ Headache at the top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Muscle spasms
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck tension
- ☐ Shoulder tension
- ☐ Limited range of motion in neck
- ☐ Limited range of motion in shoulder
- ☐ Alcohol consumption (per day: _____)
- ☐ Recreational drug use (which: _____)
- ☐ High-pitched ringing in ears
- ☐ Gallstones
- ☐ STD's (which: _____)
- ☐ Unable to adapt to stress

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Kidney Function (Overall Temperature)

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temp. sensation
- ☐ Cold body temp. sensation
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet & chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Do you take water to bed

TOTAL BOXES CHECKED: _____

Kidney (Urinary Bladder Function)

- ☐ Frequent cavities, teeth problems
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Lack of bladder control
- ☐ Wake during the night to urinate
- ☐ Fear
- ☐ Easily Startled

TOTAL BOXES CHECKED: _____

Urination (Bladder Function)

- ☐ Color: Pale ___ Dark Yellow ___ Clear ___
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning sensation
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

TOTAL BOXES CHECKED: _____

Libido

- ☐ Low
- ☐ Normal
- ☐ High

Health History Questionnaire

WOMEN ONLY

Do you have a regular menstrual cycle?:	☐ **Yes**	☐ **No**
Are you pregnant?:	☐ **Yes**	☐ **No**
Do you have bleeding between periods?	☐ **Yes**	☐ **No**
Do you have a vaginal discharge?	☐ **Yes**	☐ **No**

Menstrual Cycle Symptoms

- ☐ **Nausea**
- ☐ **Vomiting**
- ☐ **Food cravings**
- ☐ **Water retention**
- ☐ **Breast swelling**
- ☐ **Breast tenderness**
- ☐ **Headaches**
- ☐ **Migraines**
- ☐ **Dull pain**
- ☐ **Sharp pain**
- ☐ **Depression**
- ☐ **Irritability**
- ☐ **Anxiety**
- ☐ **Other: _____**

TOTAL BOXES CHECKED: _____

MEN ONLY

- ☐ **Swollen testes**
- ☐ **Testicular pain**
- ☐ **Impotence**
- ☐ **Premature ejaculation**
- ☐ **Coldness or numbness external genitalia**
- ☐ **Other: _____**

TOTAL BOXES CHECKED: _____