Waitlist Patient Questionnaire

The single most important criteria for effective case management is a comprehensive and detailed health history. Please answer the following questions with as much detail as possible. It is important for me to know everything about you and your case. Even when you feel the questions may not be directly relevant to your situation, please do your best to answer them. It takes tremendous time and energy for any healthcare provider to manage a complicated case. My practice is limited to a small number of patients and therefore the case review process is very important. Instructions: Please type (if possible) answers to the following questions with as much detail as possible. Click in each grey box and begin typing.

(NOTE: If you are completing this for a child, please complete the questions relating to the child, not yourself. There are also *additional* questions specifically for children at the end)

**Name**

**Date of Birth**       Age:

**Mobile Number**

**Emai**l       Date:

### HEALTH HISTORY QUESTIONS

1. *Why have you come to see me? Please list your five major health concerns in order of importance and how long have you had each of these?*

1. *What other Practitioners have you seen?*
2. *Please list your family health history. Please consider any cancer, heart issues or stroke, auto immune conditions (eg. coeliac disease, thyroid issues, lupus, rheumatoid arthritis), any food intolerance, mental health / mood issues.)*

1. *Please list any childhood health issues you had: (eg asthma, eczema, recurrent respiratory conditions like ear/ nose/ throat/ lung infections and any food intolerances).*

1. *What was your temperament like as a child? (eg. anxious, easygoing, withdrawn, shy, angry).*

1. *Are there any significant medical issues that have required hospitalisation or treatment in the past?*

1. *Have you had any operations?*

1. *Any pregnancies or fertility/ pregnancy issues?*

1. *Are there any significant relevant tests or investigations that have been done? What were the results? (Please arrange any past results to be sent to Northside Health or bring copies with you).*

1. *List any medications or supplements you are taking or have recently ceased.*

1. *List any allergies (to medications, inhaled things or foods) and what the reaction is.*

1. *List any treatments, medications, or supplements that have improved your health:*

1. *List any treatments, medications, or supplements that have caused reactions or decreased your health:*

1. *Are you smoking or have you ever smoked? List usual daily amount. List any other substances used.*

1. *Are you on any particular diet (Eg Paleo, gluten free, vegetarian, GAPS); for how long and how strictly?*

1. *What foods, if any, do you really love/ crave and would find difficult to give up?*
2. *Describe what you typically eat in a day and the usual TIME of day you eat each meal:*

* *Breakfast*
* *Snack*
* *Lunch*
* *Snack*
* *Dinner and dessert*
* *Snack*
* *Before bed*
* *Do you wake up hungry in the night?*

1. *Describe what you typically drink in a day (Eg. 3 cups water):*
2. *Water*

*Tea*

*Coffee*

*Soft Drinks*

*Milk*

*Fruit Juice*

*Alcohol**and on how many days per week do you drink alcohol*

1. *How many pieces of fruit do you usually eat per day? (list type of fruit)*

1. *Are there any food intolerances you have identified or foods that are not good for you? (list the symptoms or problems caused)*

1. *Do you have issues or concerns with any of the following (or have had in the past): If yes, please briefly describe:*
2. *Mood (eg depression, anxiety)*

1. *Do you have any sleep issues?*

1. *Hormones (irregular, heavy or painful periods, PMS or premenstrual issues, endometriosis)*

1. *Gut (eg bloating, pain, constipation, diarrhoea, reflux, heartburn)*

1. *Skin (eg rashes, itching, eczema, dryness, psoriasis)*

1. *Fatigue. Brain fog.*

1. *Blood Pressure (including dizziness or fainting easily)*

1. *What work do you do? Do you enjoy your work? Do you believe it contributes to your health issues?*

1. *Please list any activities, sports or hobbies that are important in your daily life.*
2. *Rate your level of stress on a scale of 1 to 10 during an average week.*

1. *Are there emotional or psychological issues that may be contributing to your health problems? If so, please explain them briefly.*

1. *What do you consider a realistic window of time to see changes in your health whilst working with me?*

1. ***What obstacles or beliefs, if any, stand in the way of you*** *recovering* ***your health?***

### Additional Questions for Children

If you are bringing a child in, please answer the following additional questions.

1. *Please describe any issues during pregnancy.*

1. *Please briefly describe the birth story for the child (Eg Caesarean and why).*

1. *Describe the breast feeding history of the child and any formula use.*

1. *Vaccination history and any reactions or issues around vaccines.*

1. *Have there been ANY food reactions or intolerances in the past?*

1. *Are there any food intolerances in the close family?*

1. *Describe any issues in infancy including sleep issues.*

1. *Please describe any behavioural issues. List any diagnoses that have been made and at what age (Eg. ADHD, sensory processing, autism spectrum).*