Kathryn Moloney – Naturopath

herbal medicine ✣ nutritional medicine ✣ pregnancy support
IVF support ✣ dietary and lifestyle advice ✣ natural fertility ✣ birth attendant

New Female Client Questionnaire

Skype/phone consultation patients – please fill out, save this as '*your name* initial patient form' and email back to me at health@kathrynmoloney.com.au
Please attach any relevant blood test results from the past 18 months.
Please highlight in a colour or make bold any answers that are correct for you

Date:

Name::		DOB::	Age::
Address::		Postcode::	
Phone::	Occupation::	Blood type ::	
Next-of-kin::	R/ship to patient:	Telephone::	
Email address::		Skype name ::	

Private Health Insurer _____

Referred by ::

- Friend / Word of mouth
- Doctor/Midwife/ Practitioner Name of referee :: _____
- Direct search for Kathryn Moloney Naturopath
- Google search (what did you search for?) _____
- Yellow pages Natural Therapy Pages Online forum
- Other online advertiser _____
- Other _____

What would you like to achieve from naturopathic treatment?

Current medication (please list name of medication, what you are using it for and dosage)?	Natural medicines/vitamins (if so, please list)?

Do you give permission for me to contact your doctor/obstetrician/practitioner if relevant? Yes/No
Name and address of your Doctor &/or Obstetrician &/or Practitioner:

Am I able to discuss your health and test results with your partner if required? Yes/No

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Main reason for your appointment (please include your symptoms and duration)::

Allergies (environmental, medicine or food-related)?	**Operations?**
Major illness as a child/teenager?	**Regular exercise (type and how often)?**

FAMILY HISTORY: Do your parents, grandparents or siblings suffer from any of the following: (please highlight)

Allergies Arthritis Cancer Depression Diabetes Hay fever Heart disease

Hepatitis High blood pressure High Cholesterol Kidney problems Liver disease

Thyroid problems Any other major health problems?

GENERAL HEALTH

In order for me to get a better idea of how your body is functioning as a whole, it is important to see how the systems of your body are functioning. Under each section, please indicate if you suffer from any of the listed problems highlighting the correct response or answering in the space provided.

Do you **currently** suffer from any of the following? (Please highlight)

HEAD/NECK:

Dandruff Sore neck/neck problems Headaches Migraines
Swollen glands in neck Dizziness/light headedness Excess hair loss

EYES/EARS/NOSE/MOUTH:

Blurred vision	Frequent cold/flu	Ringing in the ear	Cold sores
Frequent nose bleeds	Runny nose	Dry, cracked lips	Hay fever
Sinus problems	Dry eyes	Poor vision	Styes/eye blisters
Dry mouth	Puffy eyes	Tired, watery eyes	Ear aches
Bleeding gums	Trouble hearing	Red eyes	Eyelid twitches

RESPIRATORY:

Any lung problems	Frequent coughing	Shortness of breath	Asthma	Hoarse voice
Sneezing attack	Bronchitis	Irregular breathing	Sore throat	

How many times a year do you suffer from cold/flu?

SKIN:

Acne	Eczema/Dermatitis	Oily skin	Bruise easily
Psoriasis	Flaky skin	Cracked skin	Itchy skin
Skin rashes	Dry skin	Cuts/wounds take a long time to heal	

URINARY:

Blood in the urine Pain or burning upon urination Frequent urination
Urination during night
Colour of urine ::
Have you ever suffered from any urinary infections? Yes/No
Have you ever had any kidney problems? Yes/No

DIGESTIVE:

Flatulence, wind, gas	Bad breath	Frequent vomiting
Itchy anus	Fatigue relieved by eating	Faintness if meals delayed
Laxatives used often	Difficulty swallowing	Stomach pains
Haemorrhoids	Nervous/"butterfly stomach"	Indigestion
Excessive appetite	Heartburn	Reduced appetite

Bloating around your stomach after meal Yes/No
Burning stomach sensations relieved by eating Yes/No
Need to eat often or get hunger pains or faintness Yes/No
Eat a lot but never seem to gain weight Yes/No
Heart palpitations if meals missed or delayed Yes/No
History of gallstones or gallbladder attacks Yes/No

How often do you have a bowel motion (e.g. once a day, once a week etc.)?

Is your bowel movement: well formed loose consists of many pieces

Do you ever see undigested food in your bowel movement? Yes/No
Is there any bleeding or mucus associated with passing a bowel motion? Yes/No
Do you suffer from diarrhoea or constipation, or both? Yes/No/Both

LIVER:

Are you hungry when you wake in the morning? Yes/No
How soon after waking do you feel hungry? Immediately Within: ½hr 1hr 2hrs 3hrs Lunchtime
How do you feel after eating fatty food? Normal Sluggish Nauseous Happy Other

HEART/CIRCULATION:

Burning feet
Cold feet/hands
Chest pain
Chest pain on exertion
Low blood pressure
Palpitations
High blood pressure
High cholesterol
Swollen ankles
Varicose veins

MUSCULOSKELETAL:

Joint pain Muscle aches Joint stiffness after rising Muscle cramps

BLOOD SUGAR:

Diabetes
Crave sugar If so, what time of day?
Get shaky or irritable when hungry
Feel tired after eating
Abnormal thirst
Irritable before meals
Crave sweet food or coffee in the afternoon

OTHERS:

Can't gain weight
Have trouble losing weight
Get "drowsy" often
Night sweats
Intolerance to heat
Intolerance to cold
Sweat excessively
Feel cold more than others

FOR WOMEN WHO ARE MENOPAUSAL OR POST-MENOPAUSE:

Date of last menstrual period?
Have you had a hysterectomy? Yes/No If yes, ovaries removed/uterus removed
Did you have any reproductive issues before menopause? Please list:

What symptoms do you experience? (please highlight)

Hot flushes Night sweats Vaginal dryness Reduced libido

Other :: _____

FOR WOMEN WHO ARE (OR ARE OF THE AGE TO BE) HAVING A PERIOD:

Are you currently using contraception? Yes/No

If so, what method?

Have you ever taken the oral contraceptive pill? Yes/No Name of Pill?

What dates? From: To:

If so, was there any delay in the return of your periods once you stopped taking the pill? Yes/No

Have you ever used the IUD? Yes/No A diaphragm? Yes/No

How often do you get your period (i.e. every 28 days, every 20 days etc.)?
If it varies, please given shortest and longest:

Age of first menstrual period?

In regards to your period:

- How many days does it last for?
- What colour is it? (i.e. dark red, light brown etc)
- Are there clots? Never/occasionally/usually/always
- Do you experience spotting before your period starts? Yes/No If so, for how many days?
- Do you experience mid-cycle spotting? Yes/No If yes, please give details
- Do you experience mid-cycle pain? Yes/No If yes, please give details

Do you need to take painkillers? Never/sometimes/usually/always
If so, for how many days before/during your period and what medication do you use?

Have there been any recent changes to your period?

Do you experience ::
Vaginal itchiness White vaginal discharge
Reduced sexual desire/low libido Pain during or after sex
Facial hair

If you have children, did you have difficulties with the pregnancy(ies) or birth(s)?

Please give the severity, number or days and timing of the following symptoms:

	None/Slight/ Moderate/Severe	Number of days	Before/During period
Abdominal cramping/aching			
Lower back pain/ache			
Nausea/vomiting (specify which)			
Headaches			
Constipation/Diarrhoea			
Skin problems/acne			
Sore breasts/nipples (specify which)			
Fluid retention			
Irritable/Depressed (specify which)			
Fatigue			
Food cravings			

LIFESTYLE:

Do you:

- Smoke? (If yes, how often and how long have you been a smoker?)
  Have you been a smoker in the past? Yes/No

- Drink alcohol? If yes, how many glasses would you have an average per week?

- Take any social/recreational drugs? (e.g. marijuana) Yes/No
  Have you taken any in the past? Yes/No

SLEEP:

Do you have difficulty getting off to sleep? Yes/No
(If so, please indicate how long it usually takes you to fall asleep)

Do you wake often during the night? Yes/No
(If so, do you have difficulty getting back to sleep?)

How many hours sleep do you get per night?

ENERGY:

How are your energy levels most of the time?
Please rate your energy levels out of 10 (10 = maximum energy, 0 = extremely fatigued)
Upon waking /10 Mid-morning /10 Mid-afternoon /10
Evening /10

If you have not rated your energy levels as 10/10, then please indicate when they were last 10/10.

NERVOUS SYSTEM:

Anxiety	Irritability	Poor concentration	Blackouts
Mood swings	Poor memory	Depression	Panic attacks
Trembling/Shakiness	Fainting		

Do you feel like you are under a lot of stress? Yes/No

If yes, what is causing your stress?

Do you have any techniques for dealing with stress?

Is there anything else that you would like to tell me?

I, have been advised by Kathryn Moloney, that she is not a medical doctor and that this clinic is not a medical practice. As such Kathryn Moloney does not practice or prescribe allopathic medicine. I understand that she is a naturopath & herbalist by Australian training. As such she seeks to activate and support the self-healing mechanisms of the body. She utilises Naturopathic Medicines and encourages Preventative Health Care in the form of dietary, exercise, lifestyle & attitude management.

Y (please highlight) I give my permission for my health history to be kept on file for the purpose of naturopathic care planning &prescribing.

Y I give Kathryn Moloney permission to access past & current records from other health professionals I have, or am seeing as appropriate.

Y I give Kathryn Moloney permission to allow my partner/other to take messages by phone regarding my care or pick up naturopathic medicines for me as appropriate.

To the best of my ability all the information given here is a true and accurate representation of my /my child's health.

Signed	Date
Signature Parent or Guardian (for children under age 18 yrs)	Date

Thank you for taking the time to fill out this form. I look forward to speaking with you further

Kathryn Moloney BHSc (Naturopathy), Certificate in Natural Fertility Education, Birth Attendant
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