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| Nicola Dean  Medical herbalist-Naturopath | | | | | | | | | | | | | | |
| HEALTH APPRAISAL QUESTIONNAIRE | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Name | | |  | | **🞎 M** **🞎 F** | | | DOB: |  | | | | | | |
| Address | | | | | | | | | | | | | | |
| Telephone |  | | | Mobile | |  | | | | | | | | |
| Email |  | | | Doctor’s Name | |  | | | | | | | | |
| Job Title: |  | | | Family status: | |  | | | | | | | | |
| *How did you find out about this clinic?* |  | | |  | |  | | | | | | | | |
| Presenting symptoms | | | | | | | | | | | | | | |
| Please list the main health issues you wish to discuss: | | | | | | | | | | | | | | |
| section 2 medical history | | | | | | | | | | | | | | |
| 1. Did you suffer any of the following as a child? (more than 1 OK) | | 🞎 Infantile eczema | | 🞎 Recurrent tonsillitis + antibiotics | | | 🞎 Asthma | | | | | | |
| 🞎 Recurrent middle ear infections | | 🞎 Hospitalisation, why? | | | 🞎 other please state: | | | | | | |
| 2. Have any of the following caused you health problems in the past? (more than 1 OK) **Other, Please state:** | | 🞎 Allergy (asthma, hayfever, dermatitis etc | | 🞎 Diabetes | | | 🞎 Heart disease/attack | | | | | | |
| 🞎 Cancer, type? | | 🞎 Raised blood pressure or cholesterol | | | 🞎 Chronic respiratory disease (incl. asthma) | | | | | | |
| 🞎 Hiatus hernia with reflux | | 🞎 Peptic ulcer | | | 🞎 Ulcerative colitis or Crohn’s disease | | | | | | |
| 🞎 Irritable bowel syndrome | | 🞎 Arthritis or autoimmune disease | | | 🞎 Osteoporosis | | | | | | |
| 🞎 Nervous system or brain disease | | 🞎 Immune system disorder | | | 🞎 Hepatitis (B, C or toxic) | | | | | | |
| 🞎 HIV/AIDS | | 🞎 Chronic fatigue syndrome | | | 🞎 Chemical exposure causing injury | | | | | | |
| 3. Have you ever had? | | 🞎 Radiation therapy (cancer, skin conditions etc) | | 🞎 Chemotherapy | | | 🞎 Long term prescription medications (>5 years) | | | | | | |
| 🞎 Tropical or parasitic bowel infections | | 🞎 Accidental or intentional drug overdose | | | 🞎Accidental or intentional poisoning | | | | | | |
| 🞎 More than 20 x-rays in your life (incl. dental) | | 🞎 Mercury amalgam fillings (more than 4 fillings) | | | 🞎 Mercury amalgam fillings (for more than 10 years) | | | | | | |
| 🞎 Or been admitted to hospital for any other reason (please list) | | | | | | | | | | | |
| 4. In the past 6 months, have any of the following been a significant problem? (more than 1 OK) | | 🞎 Headaches (not migraines) | | 🞎 Migraine headaches | | | 🞎 Heartburn/reflux | | | | | | |
| 🞎 Diarrhoea | | 🞎 Constipation | | | 🞎 Blood in bowel motions | | | | | | |
| 🞎 Chest pain | | 🞎 Palpitations or missed heartbeats | | | 🞎 Shortness of breath on exertion | | | | | | |
| 🞎 Back pain | | 🞎 Joint pain | | | 🞎 Joint swelling or redness | | | | | | |
| 🞎 Unexplained muscle pain or tenderness | | 🞎 Change in the appearance of a mole or freckle | | | 🞎 New or changing breast lump (women only) | | | | | | |
| 🞎 Excessive thirst/urination | | 🞎 Prolonged loss of appetite | | | 🞎 Dizziness or vertigo | | | | | | |
| 🞎 Menstrual problems | | 🞎 Severe or prolonged unexplained fatigue | | | 🞎 Recurrent/prolonged infections | | | | | | |
| 🞎 Impaired memory/concentration | | 🞎 Unexplained weight loss | | | 🞎 Unexplained weight gain | | | | | | |
| 🞎 Insomnia or change in sleep patterns | | 🞎 Anxiety or hyperventilation | | | 🞎 Suicidal thoughts | | | | | | |
| 🞎 Depression | | 🞎 Unexplained early morning waking (before sunrise) | | |  | | | | | | |
| 5. Adverse reactions – In the past 6 months, have any of the following been a significant problem (more than 1 OK) | | 🞎 Bad reactions to particular foods: | | | | | | | | | | | |
| 🞎 Bad reactions to chemicals: | | | | |  | | | | | | |
| 🞎 Bad reactions to vaccinations: | | 🞎 Bad reactions to medical drugs or natural medicines: | | |  | | | | | | |
| 6. Have any of your immediate family (mother, father or siblings) suffered: (more than 1 OK) | | | Cancer  Diabetes  Heart Disease/attack  Stroke  Immune system disorder  Chronic respiratory disease  Allergy | | 🞎 M 🞎 F 🞎 Sib  🞎 M 🞎 F 🞎 Sib  🞎 M 🞎 F 🞎 Sib  🞎 M 🞎 F 🞎 Sib  🞎 M 🞎 F 🞎 Sib  🞎 M 🞎 F 🞎 Sib  🞎 M 🞎 F 🞎 Sib | | | Please give detail where appropriate: | | | | | | | |
| SECTION 3 MEDICATION HISTORY | | | | | | | | | | | | | | |
| 7. Are you now, or have you ever been, on long term antibiotics (acne, respiratory infections etc) | | | | | | | | | | 🞎 | Yes | 🞎 | No | |
| 8. Medications – In the past year, have you used any of the following regularly? (please list if known) | | 🞎 Antibiotics 🞎 Antidepressants | | | | | | | | | | | |
| 🞎 Antihistamines 🞎 Anti-inflammatory drugs (NSAIDs) | | | | | | | | | | | |
| 🞎 Asthma medications 🞎 Blood pressure tablets | | | | | | | | | | | |
| 🞎 Diuretics 🞎 Cholesterol lowering medications | | | | | | | | | | | |
| 🞎 Hormone therapy (oral contraceptive, HRT) 🞎 Strong pain relievers | | | | | | | | | | | |
| 🞎 Sedatives 🞎 Oral steroids (cortisone) | | | | | | | | | | | |
| 🞎 Other, please state: | | | | | | | | | | | |
| **COMPLEMENTARY & ALTERNATIVE MEDICINES** | | | | | | | | | | | |
| 🞎 Nutritional supplements: | | | | | | | | | | | |
| 🞎 Herbal medications: | | | | | | | | | | | |
| 🞎 Any other alternative therapies: | | | | | | | | | | | |
| 9. Do you currently smoke? (if so, how many per day) ……………………………………. | | | | | | | | | | 🞎 | Yes | 🞎 | No | |
| **10. Do you now use, or have you ever regularly used the following? (all answers are confidential)** | | 🞎 Marijuana | | 🞎 Anabolic steroids (or other) | | | 🞎 Ecstasy or amphetamines (or other) | | | | | | |
| 🞎 Cocaine (or other) | | 🞎 Narcotics or injectable drugs | | | 🞎 Other drugs not specified | | | | | | |
| SECTION 4 FITNESS | | | | | | | | | | | | | | |
| **11. Over the last month how often have you engaged in any of the following:** swimming, dancing, jogging, fitness walking, aerobics, rowing, cycling etc | | 🞎 Not at all | | 🞎 1-2 times per week | | | 🞎 3-4 times per week | | | | | | |
| 🞎 5-6 times per week | | 🞎 More than 6 times per week | | |  | | | | | | |
| **12. How long would you usually do this activity?** | | 🞎 less than 10 minutes | | 🞎 10-20 minutes | | | 🞎 20-30 minutes | | | | | | |
| 🞎 30-45 minutes | | 🞎 Longer than 45 minutes | | |  | | | | | | |
| **13. Which of the following scenarios is most indicative of your exercise regime?** | | 🞎 Non-existent | | 🞎 at least once per day | | | 🞎 a few days on then one day off | | | | | | |
| 🞎 every second day | | 🞎 A few days on then a few days off | | |  | | | | | | |
| SECTION 5 LIFESTYLE & WORK | | | | | | | | | | | | | | |
| **14. How many hours per week would you have direct sunlight exposure?** | | 🞎 None (avoid direct sunlight) | | 🞎 less than an hour per week | | | 🞎 one to four hours per week | | | | | | |
| 🞎 over four hours per week | |  | | |  | | | | | | |
| **15. Which of the following activities do you regularly engage in?** | | 🞎 meditation or relaxation therapy | | 🞎 yoga | | | 🞎 Tai Chi or similar | | | | | | |
| 🞎 A hobby or pastime which I love | | 🞎 Outdoor activities with family and friends | | | 🞎 Other relaxing and enjoyable activities | | | | | | |
| **16. How many hours do you work per week (paid or unpaid, incl. housework)** | | 🞎 none | | 🞎 1 – 10 hours | | | 🞎 11 – 40 hours | | | | | | |
| 🞎 41 – 60 hours | | 🞎 61 – 80 hours | | | 🞎 81 plus hours per week | | | | | | |
| **17. Which of the following best describes the type of work you generally do?** | | 🞎 none | | 🞎 Mainly sedentary, minimal physical activity | | | 🞎 Alternates between sedentary & moderate activity | | | | | | |
| 🞎 Moderate physical activity | | 🞎 Strenuous physical activity | | |  | | | | | | |
| **18. Which of the following best describes how you find your work?** | | 🞎 Joyful and easy to manage | | 🞎 Mildly stressful, but not too difficult | | | 🞎 Moderately stressful, could be improved | | | | | | |
| 🞎 Very stressful, wish I could change jobs | | 🞎 Extremely stressful, high pressure job | | |  | | | | | | |
| SECTION 6 STRESS | | | | | | | | | | | | | | |
| **19. Which of the following best describes your important personal relationships?** | | 🞎 Joyful and positive almost all the time | | 🞎 Generally very enjoyable, occasional stress | | | 🞎 Mildly stressful, but not of concern | | | | | | |
| 🞎 Moderately stressful, needs to be worked on | | 🞎 Very stressful and unfulfilling | | | 🞎 Extremely stressful and at risk of break-up | | | | | | |
| **20. Which of the following have you experienced in the past 12 months?** | | 🞎 Bereavement | | 🞎 Divorce or relationship breakdown | | | 🞎 Pregnancy or birth of child | | | | | | |
| 🞎 Job loss or demotion | | 🞎 Job promotion, change or relocation | | | 🞎 Injury preventing work | | | | | | |
| 🞎 Unemployment | | 🞎 Illness of self or immediate family | | | 🞎 Moved home | | | | | | |
| 🞎 Child leaving home | | 🞎 Recurrent anxiety or depression | | | 🞎 Sleep disturbances | | | | | | |
| SECTION 7 ENVIRONMENT – WORK AND HOME | | | | | | | | | | | | | | |
| **21. Which of the following chemicals are regularly used in your home? (check all that apply)** | | 🞎 Indoor pesticides (sprays, flea bombs etc | | 🞎 Pressure pack sprays (deodorant, hair spray etc) | | | 🞎 Bleach or ammonia cleaning products | | | | | | |
| 🞎 Animal flea treatments | | 🞎 Garden chemicals (herbicides, insecticides etc) | | | 🞎 Glues, solvents (craft, hobbies, motor etc) | | | | | | |
| 🞎 Gas, oil, kerosene or coal heating | |  | | |  | | | | | | |
| **22. Have you ever been regularly exposed to any of the following?** | | 🞎 Lead or heavy metals (incl. renovation, traffic etc) | | 🞎 Petrochemicals or heavy city pollution | | | 🞎 Home pest extermination | | | | | | |
| 🞎 Agricultural pesticide exposure | | 🞎 Accidental poisoning in work or home | | | 🞎 Paints, glues, solvents, printers | | | | | | |
| 🞎 Other (please list) | | | | | | | | | | | |
| SECTION 8 STATISTICS | | | | | | | | | | | | | | |
| **Please advise the following (where you are able)** | | Weight…………………………………………  Blood pressure………………………………..  Blood Type……………………………………… | | | | | | | | | | | |

ADDITIONAL NOTES:

PTO..

CLIENT CONSENT AND DISCLAIMER FORM:

I ………………………………………………………………………………….. confirm that the information I have given in this Health Appraisal Questionnaire (HAQ) is true and correct.

I understand that all questions contained in this appraisal are strictly confidential and will become part of my naturopathic file. The appraisal is designed to provide important information, helping to identify my health risk factors. This information provides unique opportunities for early intervention and prevention, and allows me and my naturopath to assess progress over time.

I understand that there is no assurance of achieving a desired or specific result in treatment. Although everything possible is done to ensure a positive outcome, each patient responds differently to care. Progress in treatment is based on many factors, including my commitment to making lifestyle changes, compliance with suggestions, and adherence to the treatment plan. By commencing treatment, I agree that Nicola Dean is not responsible for the success or failure of the treatment outcome.

I understand that Nicola Dean is *not* a qualified medical doctor and that any naturopathic or other healthcare or healthcare related decision should be made in consultation with my qualified medical healthcare provider.

As a professional member of the New Zealand Association of Medical Herbalists Nicola Dean is bound by a formal Constitution and strict Code of Ethics (see <http://nzamh.org.nz/about-nzamh>). A Practice complaints procedure is available on request.

Signed ……………………………………………………………………………………

Date ……………………………………………………………………………………….