





Family history: Diabetes: \_\_\_\_\_ Heart disease: \_\_\_\_\_ Asthma: \_\_\_\_\_  
Gallbladder disease: \_\_\_\_\_ Kidney disease: \_\_\_\_\_  
Arthritis: \_\_\_\_\_ Stomach disorders: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Type of cancer: \_\_\_\_\_  
Other: \_\_\_\_\_

Children: \_\_\_\_\_ # of Pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortion: \_\_\_\_\_

Complications: \_\_\_\_\_

Mother: Age: \_\_\_\_\_ Died from: \_\_\_\_\_

Grandmother: Age: \_\_\_\_\_ Died from: \_\_\_\_\_

Grandfather: Age: \_\_\_\_\_ Died from: \_\_\_\_\_

Father: Age: \_\_\_\_\_ Died from: \_\_\_\_\_

Grandmother: Age: \_\_\_\_\_ Died from: \_\_\_\_\_

Grandfather: Age: \_\_\_\_\_ Died from: \_\_\_\_\_

Daily habits: Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Sugar \_\_\_\_\_ Chocolate \_\_\_\_\_

Alcohol \_\_\_\_\_ Cigarettes \_\_\_\_\_ Drugs \_\_\_\_\_ Laxatives \_\_\_\_\_

Work \_\_\_\_\_ hrs/wk Sleep \_\_\_\_\_ hrs. Exercise \_\_\_\_\_ times/wk

Please describe what you are currently eating for:

Breakfast \_\_\_\_\_

\_\_\_\_\_

Lunch \_\_\_\_\_

\_\_\_\_\_

Dinner \_\_\_\_\_

\_\_\_\_\_

Snacks \_\_\_\_\_

My intake of cold water fatty fish (wild caught salmon, sardines etc) per week is:

None  1 to 2  3 or more

How many serves of vegetables (raw or cooked) do you eat daily, including potatoes? (Example serve: five cherry tomatoes, five sticks of celery, or one whole carrot)

0 to 1 per day  2-3 per day  4 or more per day

What description below best describes your joint health when not taking over-the-counter medication or joint support supplements

Not joint pain  Periodic intervals of pain  Continual joint pain

What are your top three priorities from the follow list:

- Improving digestive health
- Enhancing athletic performance and endurance
- Improving the look and feel of my skin
- Boosting my immune system
- Increasing lean muscle mass
- Increasing my energy levels naturally
- Supporting joint health
- Strengthening my heart

List any nutritional supplements you are currently taking, including name brands and amounts:

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List any prescription medication you are currently taking and dosages: \_\_\_\_\_

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Operations/ Accidents or Injuries (what & when): \_\_\_\_\_

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### HEALTH CHECK LIST

Digestive Tract:	<input type="checkbox"/>	Nausea	Head:	<input type="checkbox"/>	Headaches		
	<input type="checkbox"/>	Diarrhea		<input type="checkbox"/>	Dizziness		
	<input type="checkbox"/>	Constipation		Lungs:	<input type="checkbox"/>	Chest congestion	
	<input type="checkbox"/>	Bloating			<input type="checkbox"/>	Asthma	
	<input type="checkbox"/>	Belching			<input type="checkbox"/>	Shortness of breath	
	<input type="checkbox"/>	Excess Gas			Mind:	<input type="checkbox"/>	Poor memory
	<input type="checkbox"/>	Heartburn				<input type="checkbox"/>	Confusion
Ears:	<input type="checkbox"/>	Itchy ears	<input type="checkbox"/>	Learning			
	<input type="checkbox"/>	Earaches	Disabilities:	<input type="checkbox"/>	Stuttering		
	<input type="checkbox"/>	Ear Infections		<input type="checkbox"/>	Poor concentration		
	<input type="checkbox"/>	Ear Drainage		Mouth/Throat:	<input type="checkbox"/>	Chronic	
	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>		Sore throat		
	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>		Swollen gums		
Emotions:	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>		Canker sores		
	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>		Sensitive teeth-nerves		
	<input type="checkbox"/>	Nervousness	Nose:	<input type="checkbox"/>	Stuffy nose		
	<input type="checkbox"/>	Anger/Irritability		<input type="checkbox"/>	Sinus problems		
	<input type="checkbox"/>	Depression		<input type="checkbox"/>	Hay Fever		
Energy:	<input type="checkbox"/>	Fatigue		<input type="checkbox"/>	Sneezing		
	<input type="checkbox"/>	Apathy	<input type="checkbox"/>	Excess Mucus			
Lethargy:	<input type="checkbox"/>	Hyperactivity	Skin:	<input type="checkbox"/>	Acne		
	<input type="checkbox"/>	Restlessness		<input type="checkbox"/>	Hives or rashes		
Eyes:	<input type="checkbox"/>	Watery Eyes		<input type="checkbox"/>	Hair loss		
	<input type="checkbox"/>	Itchy or red eyes		<input type="checkbox"/>	Excess sweating		
	<input type="checkbox"/>	Blurred Vision	Weight:	<input type="checkbox"/>	Binge eating		
	<input type="checkbox"/>	Tunnel Vision		<input type="checkbox"/>	Cravings		
Heart:	<input type="checkbox"/>	Irregular heartbeat		<input type="checkbox"/>	Excessive weight		
	<input type="checkbox"/>	Rapid heartbeat		<input type="checkbox"/>	Compulsive eating		
	<input type="checkbox"/>	Chest pains		<input type="checkbox"/>	Water retention		
Joint/Muscle:	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Under weight			
	<input type="checkbox"/>	Arthritis	Other:	<input type="checkbox"/>	Frequent illness		
	<input type="checkbox"/>	Muscle pain		<input type="checkbox"/>	Frequent urination		
	<input type="checkbox"/>	Varicose veins					



\_\_\_\_\_ Dizziness  
 \_\_\_\_\_

\_\_\_\_\_ Genital itch  
 \_\_\_\_\_ Discharge  
 \_\_\_\_\_

Do you suffer from thrush? Yes \_\_\_\_\_ No \_\_\_\_\_  
 When was the last bout?  
 \_\_\_\_\_  
 \_\_\_\_\_

Initial Consultation (90 minutes)	\$142.00 Au
Initial Consultation (120 minutes)	\$190.00 Au
Initial Consultation (For every ½ hour over)	\$50.00 Au
Follow-up Consultation (1 hour)	\$95.00 Au
½ Hour Follow-up Consultation	\$65.00 Au

Make checks payable/posted to: Kathy Edwards  
 P.O. Box 284  
 South West Rocks, NSW 2431

For credit card payment, please give your credit card information when scheduling your appointment.

Your card will be charged only after the consultation is completed.

Credit Card Type:  Visa  MasterCard  Union Pay

Name on card.....

Card number .....

Expiry date .... / ..... Amount \$.....

Signature .....

