

# Health Assessment Form

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Katherine Sabathie-Edwards

Naturopath ~ Holistic Health coach

Consultation Date: \_\_\_\_\_

Consultation scheduling- + 61 2 677 15 496

Consultation Time: \_\_\_\_\_

Fax: 61 2 677 15 496

The following form is to be completed prior to your consultation and faxed to the above number. Upon receiving the questionnaire, please call our office on + 61 2 677 15 496 to schedule your appointment. PLEASE NOTE: Sydney Australia time zone. 9am – 5pm or email to schedule your appointment.

Please complete the Health History Questionnaire. If you have any test results, etc. please feel free to attach copies along with any pertinent information not covered here. All client information is kept strictly confidential. Thank You.

Name: _____	Phone: _____
Mobile _____	
Address: _____	
City: _____	State: _____ Post Code: _____
Occupation: _____	Email: _____

Age: _____	Height: _____	Weight: _____	Blood Type: _____
Waist measurement _____	Are you on any special diet?		
Describe your current symptoms: _____			
_____			
_____			
_____			
_____			
_____			
_____			

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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: _____

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Habits: Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Sugar \_\_\_\_\_ Chocolate \_\_\_\_\_

Alcohol \_\_\_\_\_ Energy Drinks \_\_\_\_\_ Soft Drink \_\_\_\_\_

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

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

Exercise \_\_\_\_\_ times/wk type \_\_\_\_\_ Session duration \_\_\_\_\_

Please describe what you are currently eating for:

Breakfast \_\_\_\_\_

\_\_\_\_\_

Lunch \_\_\_\_\_

\_\_\_\_\_

Dinner \_\_\_\_\_

\_\_\_\_\_

Snacks \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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Operations/ Accidents or Injuries (what & when): _____
_____
_____
_____

## Stress

Tick if you have experienced any of these in the past twelve months

Work related stress		Changed Job or back to work	
Relationship issues		Divorce	
Major Illness –Self Close family member		Marriage	
Death in Family Close friend		Major Accident: Self Family member	
Moved House		Depression	
Anxiety		Birth	

## Hormonal -Female:

Hot Flushes		Mood Swings	
Irregular Menstrual Cycle		Lose of mental focus	
Depression		Sore Breast	
Fluid Retention		Loss of libido	
Fibroid Cysts, Breast Lumps		Cyclic Migraines	
Loss of skin tone		Dry vagina	
Infertility		Weight gain and resistant obesity	
Insulin resistance		Low blood sugar	
Carbohydrate cravings (sweets, cakes, chocolate, pastries etc)		Emotional outburst (crying, anger, frustration)	
Poly Cystic Ovary Syndrome		Loss of bone density	

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Have you been tested within the last two years for any of the following hormones:

DHEA \_\_\_\_\_ Cortisol \_\_\_\_\_ Testosterone \_\_\_\_\_ Estrogen \_\_\_\_\_ Progesterone \_\_\_\_\_

What were the results of those tests?

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Do you suffer from thrush? Yes \_\_\_\_\_ No \_\_\_\_\_

When was the last bout?

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From the following list what do you believe might be causing your fatigue:

Airborne: \_\_\_\_\_ Food: \_\_\_\_\_ Poor sleep habits: \_\_\_\_\_ Thyroid: \_\_\_\_\_ Stress: \_\_\_\_\_

Allergies: (Please list known) \_\_\_\_\_

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Have you been tested for allergies? When?

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Describe your hormone activity (your period as a teen/menopause difficulties):

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## Health Check list

Digestive Tract:	<input type="checkbox"/>	Nausea
	<input type="checkbox"/>	Diarrhea
	<input type="checkbox"/>	Constipation
	<input type="checkbox"/>	Bloating
	<input type="checkbox"/>	Belching
	<input type="checkbox"/>	Excess Gas
	<input type="checkbox"/>	Heartburn
Ears:	<input type="checkbox"/>	Itchy ears
	<input type="checkbox"/>	Earaches
	<input type="checkbox"/>	Ear Infections
	<input type="checkbox"/>	Ear Drainage
	<input type="checkbox"/>	Ringing in Ears
Emotions:	<input type="checkbox"/>	Hearing Loss
	<input type="checkbox"/>	Mood Swings
	<input type="checkbox"/>	Anxiety
	<input type="checkbox"/>	Nervousness
	<input type="checkbox"/>	Anger/Irritability
Energy:	<input type="checkbox"/>	Depression
	<input type="checkbox"/>	Fatigue
Lethargy:	<input type="checkbox"/>	Apathy
	<input type="checkbox"/>	Hyperactivity
Eyes:	<input type="checkbox"/>	Restlessness
	<input type="checkbox"/>	Watery Eyes
	<input type="checkbox"/>	Itchy or red eyes
	<input type="checkbox"/>	Blurred Vision
Heart:	<input type="checkbox"/>	Tunnel Vision
	<input type="checkbox"/>	Irregular heartbeat
	<input type="checkbox"/>	Rapid heartbeat
Joint/Muscle:	<input type="checkbox"/>	Chest pains
	<input type="checkbox"/>	Joint pain
	<input type="checkbox"/>	Arthritis
	<input type="checkbox"/>	Muscle pain
	<input type="checkbox"/>	Varicose veins
	<input type="checkbox"/>	Dizziness

Head:	<input type="checkbox"/>	Headaches
	<input type="checkbox"/>	Dizziness
Lungs:	<input type="checkbox"/>	Chest congestion
	<input type="checkbox"/>	Asthma
	<input type="checkbox"/>	Shortness of breath
Mind:	<input type="checkbox"/>	Poor memory
	<input type="checkbox"/>	Confusion
	<input type="checkbox"/>	Learning
Disabilities:	<input type="checkbox"/>	Stuttering
	<input type="checkbox"/>	Poor concentration
Mouth/Throat:	<input type="checkbox"/>	Chronic
	<input type="checkbox"/>	Sore throat
	<input type="checkbox"/>	Swollen gums
	<input type="checkbox"/>	Canker sores
	<input type="checkbox"/>	Sensitive teeth-nerves
Nose:	<input type="checkbox"/>	Stuffy nose
	<input type="checkbox"/>	Sinus problems
	<input type="checkbox"/>	Hay Fever
	<input type="checkbox"/>	Sneezing
Skin:	<input type="checkbox"/>	Excess Mucus
	<input type="checkbox"/>	Acne
	<input type="checkbox"/>	Hives or rashes
	<input type="checkbox"/>	Hair loss
Weight:	<input type="checkbox"/>	Excess sweating
	<input type="checkbox"/>	Binge eating
	<input type="checkbox"/>	Cravings
	<input type="checkbox"/>	Excessive weight
	<input type="checkbox"/>	Compulsive eating
Other:	<input type="checkbox"/>	Water retention
	<input type="checkbox"/>	Under weight
	<input type="checkbox"/>	Frequent illness
	<input type="checkbox"/>	Frequent urination
	<input type="checkbox"/>	Genital itch
	<input type="checkbox"/>	Discharge

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What have some other professionals told you about your health? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else you would like to add:

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When you have completed your Health Assessment form please email it back to [kathy@thehealthnut.com.au](mailto:kathy@thehealthnut.com.au) or fax 02.677.15.496

Initial Consultation (60 minutes)	\$125.00 Au
Initial Consultation (90 minutes)	\$170.00 Au
Initial Consultation (For every ½ hour over)	\$50.00 Au
Follow-up Consultation (45 minutes)	\$90.00 Au
½ Hour Follow-up Consultation	\$65.00 Au

Make checks payable to: Kathy Edwards  
P.O. Box 1930  
Armidale, NSW, 2350

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 .....

Call 02.677.15.496 to schedule your appointment or go to our online booking page which is working 24/7. [www.katesabathie-edwards.clickbook.net](http://www.katesabathie-edwards.clickbook.net)