Restore
Natural Health

Name:	Date:
Address:	Home Phone:
	Work Phone:
Occupation:	Mobile Phone:
Email:	Date of Birth:
How did you hear about us?	Private Health Fund:

Concerning issues:
Do you take any supplements/herbal medicines? **YES/NO** Please list:
Are you on any prescription medications? **YES/NO** Please list:
Are you currently under the care of other practitioners? **YES/NO** Please list what modalities:
Health History (please list any previous illnesses/health problems):
Do you have any allergies? **YES/NO** Please list:
Do you drink alcohol? **YES/NO** On average how much/how often?
Do you use chemicals in your home? (e.g. Bleach, chemical cleaning products, personal care products, laundry liquids, air fresheners)
Do you/have you ever smoked? **YES/NO** Do you/have you ever taken recreational drugs? **YES/NO**
Are you pregnant? **YES/NO** If so, how many weeks?
On a scale of 1-10 (10 being highest), how would you rate your stress levels?
Do you have any digestive problems? Please circle any: Diarrhoea, constipation, bloating, indigestion, heart burn, intestinal pain
Do you do regular exercise? **YES/NO** If yes, what type and how often:
Do you have a history of any of the following: Please tick as appropriate

☐ Angina	☐ Allergies	☐ Reflux oesophagitis
☐ Heart attack	☐ Stroke	☐ Glandular fever
☐ High cholesterol	☐ Liver Disease	☐ Operations
☐ Peripheral vascular disease	☐ Kidney Disease	☐ Known chemical or toxin exposure
☐ Stroke	☐ Asthma	☐ Amalgam (mercury) fillings
☐ Bleeding disorder	☐ Chronic Lung disease	☐ Root canals
☐ High blood pressure	☐ Recurrent chest infections	☐ Eczema
☐ Cancer	☐ Sinusitis	☐ Psoriasis
☐ Arthritis	☐ Stomach ulcers	☐ Sleep apnoea
☐ Diabetes	☐ Diverticular disease	☐ Migraines
☐ Thyroid disease	☐ Irritable bowel syndrome	☐ Fibroids
	☐ Crohn's Disease/Ulcerative colitis	☐ Premenstrual tension

Name:	Date:
Signature:	

CONFIDENTIAL