

Confidential Initial Health History

This is a very detailed & probably the longest questionnaire you will ever fill in. Part 1 is the most important, but the more of it you can complete before your session, the better informed I am. To do the whole thing it may take 4 hours, and you may want to call a parent to answer the questions on relatives, your birth and early life events.

This Word Doc format keeps third party data storages websites out of the picture – this is why I don't like digital forms. I prefer to keep client files offline for privacy and security.

Please complete this form in Word on a computer, and send back in Word doc format (rather than PDF) 3 days before your session if you can. If you can't get through it all, do part 1 and send the other sections through after our session.

Personal Details

Name : Email : Postal Address :	Phone :	Emergency Contact person & #:	
DOB: Age: Occupation:	Partner's name: Are you Married / Single / Partnered / Divorced / Widowed		Who do you live with?
What diet you follow: Are you Vegan? How long for?	Children's names & Ages: Are there any medical concerns with any of your children?		
Do you / have you had and EATING DISORDER? (Orthorexia / anorexia / bulimia)	Do you have a mental illness / issue? (eg OCD, bipolar, schizophrenia, depression, anxiety, suicidal)	Do you have any diagnosed / obvious Addictions? Do you Smoke? How many/week?	Do you currently have any infections?

What is your main health concern?
What else are you wanting help with?
Was there a trigger to bring about a change in your health / wellbeing (eg: infection / accident / breakup / trauma / accident / stress / surgery / colonoscopy / vaccine / gastro / problem)?
When was the last time you felt well?
In order of priority, what the top three things you want to achieve through our sessions together? <ol style="list-style-type: none"> 1. 2. 3.

What are your present obstacles to health?

Briefly, what is the story of your current issue/s, what have you tried already and how did it go?

Current Medications

Current Medications, dose, when started (year), what time you take them, and what they are for. Include medications you take occasionally, and how often you take them in a month.

Medication History

What Medications have you used in the past and what were they for? How long were you on it and when did you stop? (Include osteoporosis injections, anaesthetics, antibiotics, roacutane, the pill, HRT, etc.)

Drug Categories: have you ever used any of these? There are drug classes that are known to have long term effects. Please indicate if you have had these, the brand name and roughly what age-periods/years and how long you took them.

Painkillers: Neurofen, paracetamol, codeine, endone, morphine, voltarin, Steroids, Celebrex, Methotrexate, Opioids etc	
Contraceptives: ORAL CONTRACEPTIVE PILL, Implants - IMPLANON / DEPROPROVERA, IUD, OTHER:	
Skin : ROACUTANE for acne, Antibiotics, steroid creams, skin cancer creams OTHER:	
Mood: ANTIDEPRESSANTS, anti-anxiety, antipsychotics, sleeping tablets OTHER:	
Stomach/gut: Antacids, Somac, gastro-stop, diarrhoea medicine, laxatives etc. OTHER:	
Heart / Vascular System: Beta blockers, statins, amioadarone, digoxin, blood pressure medications, OTHER:	
Osteoporosis: Calcium carbonate, prolia, bone density injections, OTHER:	
Cancer / Disease treatments:	

Supplements

Current Supplements, including brand, how long you have taken them, what they are for, and what time in the day do you take them?

Occasional Supplements

Vaccination History (*see end of questionnaire for schedules over the years)

Please through a copy of your vaccine history (this is important). Make a note of any symptoms or issues that may have started after a round of vaccines, medications or medical interventions.

What year/s and how many doses have you had of:

Childhood vaccines: what year/s would your childhood vaccines have been (see end of form for list*)? Did you get them all?

ADDITIONAL VACCINES (eg: travel, health workers):

HPV Gardasil – (Cervical Cancer vaccine given routinely to 11 and 12 year old boys and girls in two or three doses) – any health changes after (eg: pain, swelling, redness, itching, bruising, bleeding, a lump at the shot site, sore throat, swollen glands, headache, fever, nausea, and dizziness, fainting, fever, joint pain, meningitis, shingles, chicken pox, cold sores, chronic fatigue, glandular fever, increase in infections, menstrual changes in females, abdominal pain, dizziness, cervical dysplasia later on, etc)

COVID VACCINES – which one/s and dates?

Did you get a metallic taste in your mouth while receiving the injection/s?

Any issues post injection/s (sore arm, feeling tired, fever, fatigue, joint pain, headaches, nausea, feeling off, not quite right, shortness of breath, palpitations, breathless on slightest exertion, aggravation of current conditions, flu symptoms, getting covid r the flu in the following weeks, joint inflammation, moving body pains, sleep disturbance etc)?

Boosters – which one/s & dates?

FLU SHOTS – number & years:

Have you experienced an increase in infections since the flu shot, or meningitis, joint pain, or other changes in your health over the year following the shot/s?)

Hospitalisations / Surgery

What surgeries have you had and when?	Have you had a transplant? Do you have a pacemaker? Do you have any implants or prosthetics (teeth/limbs/plates)?
Have you had any organs or tissues removed? (eg: Tonsils, appendix, gallbladder ...)?	When was your last pap smear / prostate exam & what was the result?
How many general anesthetics have you had in your life?	How many : Xrays MRIs CAT scans Radiotherapy? Chemo? Colonoscopy / gastroscopy? What for?

Details:

Accidents/Head injury History

Particularly include any time you have had a head injury - banged or bumped your head, car accident/s, sports injuries, concussions, punches, whiplash, bike accidents, falls as a child, loss of consciousness, etc.

YEAR	IMPACT

DIET - Outline your current diet & lifestyle routine:

Add Times	Diet	Lifestyle / Daily Routine
MORNING		
MID AM		
LUNCHTIME		
MID PM		
DINNER		
EVENING		

Body Weight

<p>Have you had any past issues or ongoing with your weight?</p> <p>Do you 'count calories' or monitor your fat intake? How long for?</p>	<p>Please measure your body with a tape measure: Current Weight on the scales : What is your preferred Weight: Height:</p>
<p>Tummy measurement (this is important – grab a tape measure) – i) at belly button: ii) the highest point of your belly: iii) hips (high point of bottom cm):</p>	

Exercise

<p>What exercise are you doing & how long, how often? Rate the intensity MILD/MODERATE/HIGH:</p>
<p>Would you say you are 'addicted' to exercise?</p>
<p>Is there anything that restricts or prevents you from exercising?</p>

Addictions

Addictions are things that you crave that help you feel better in the short term but are detrimental to your health in the long term, but you can't stop doing it. Do you have any addictions (food, cigarettes, drugs, repetitive behaviours, exercising, shopping, collecting things, activities, behaviors etc)

GENERAL REVIEW:

Please rate out of:10=high 5 = moderate 1 = low 0=nil

Add comments: 0= nil 10= high / severe	INITIAL	REVIEW
Energy levels overall - Indicate if varies between morning, afternoon and evening:		
Stress levels overall:		
Memory recall:		
Sense of Wellbeing:		
Your body Weight =ok – mild – mod – severely over/underweight:		
Sugar/carbohydrate cravings (<i>chocolate, sweets, sugar, bread, cake, biscuits, soft drinks, fruit juice etc</i>) = Nil-mild-mod-severe		
What do you crave?		
Rate your Skin :		
Do you get itching / rashes / hives?		
Immune System overall? How often to you get sick?		
Sinus problems (blocked, congested, Post nasal drip)		
Ears – Ringing, itching, blocked, infection		
MOOD		
Level of Anxiety (what are your triggers?):		
Depression:		
Irritability:		
Frustration:		
Teariness / Sensitivity (triggers?):		
Sadness		
Low mood:		
Anger:		
Aggressive feelings:		
LIST ANY OTHER SYMPTOMS YOU WOULD LIKE TO SEE CHANGE IN AND RATE currently:		

Chemicals / Pesticides / Poisoning / Inhalants

Have you ever been poisoned or had any type of concentrated chemical exposure? EG: Pesticides, broken thermometer, amalgam filling fall out, broken curly light bulb or fluorescent tube, banana plantation or farm spraying exposure, medical treatment issues, hairdresser, nail technician, car mechanic or other work exposure/s, lots of air travel?

Pesticides – do you / have you use/d weed chemicals, roundup, lice treatments, flea treatments on your pets, insect repellents, or other pesticide based chemicals in your environment on you're your body?

Do you use spray deodorant / hairspray / perfume?
How many years?

Women's Health

HORMONES – what is your overall sense of Hormone Balance?	
Menstrual pain:	
Breast Tenderness:	
PMS - Premenstrual Tension / Mood changes before period:	
How long was your last cycle (first day of period to day before flow of next period) Cycle length (days) : 21 / 28 / 30 / 40+ 1st day of last period – date :	
Have you started Perimenopause / Menopause? Year it started :	
Any night sweats?	
In Pregnancy did you have any issues? High blood pressure? Diabetes?	

Men's Health

Has the strength of the urine stream changed?	
Are you concerned about your prostate?	
Has your ability to develop or maintain an erection changed?	
Do you have high blood pressure/cholesterol?	
Overweight / central weight gain / man-boobs / obesity?	
Have you had your prostate tested?	
Have you ever taken testosterone, growth hormone, or Viagra?	
Other:	

Fertility (male/female)

Have you had any fertility issues?	
Have you had any IVF treatments?	
Have you or your partner had miscarriages? What year/s?	
Stillbirth?	

Mouth

<p>Do you have any mouth issues? Gingivitis / Peridontal disease / Oral infections / Bad breath? Bleeding gums? Any issues with your mouth / gums / teeth / tongue / throat / tonsils?</p> <p>Number of: Silver Fillings _____ White Fillings _____ Implants _____ Bridges _____ Any Missing Teeth? _____</p> <p>Do you have a coated tongue? Did you have braces or orthodontics? How old were you, how long were they on?</p>
<p>What toothpaste do you use? Do you use mouthwash (note brand)?</p> <p>Do you use a waterpick &/or interdental brush, how often?</p> <p>Do you brush your tongue?</p>
<p>When was your last visit to the dentist and what was it for?</p>

Nutrient Deficiencies

	YES	NO	DETAILS
White spots on nails			
Soft / peeling nails			
Brittle / splitting nails			
Vertical ridges on nails			
Horizontal dip in any nails			
Spoon nail on thumb			
Stretch marks			
Raised colloidal scars			
Easy scarring			
Easy bruising			
Gums bleed when you brush			
Pale tongue			
Lots of cracks in tongue			
Stumbling/clumsiness walking in the dark			
Diminished eyesight in the dark			
Problems with night-driving			
Hair falling out			
Bumps on the backs of arms			
Dry scaly skin			
Slow healing wounds			
Easy bruising			
Easy scarring			
Swollen neck / fat pad at base of neck			

Musculoskeletal Health

How is your body feeling?

Note areas of discomfort or issue, and rate out of 10, where 10 is strong / severe. **RECORD ANY SCARS ON YOUR BODY.**

Injuries: Pain/tension/discomfort:	Do you have any SCARS, where? Tattoos? Piercings, where?
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Rate any body pain or discomfort - **1 = low / 10 = high/severe**

Muscle tension / hardness / knots:	
Body pain:	
Headaches – frequency, intensity etc:	
Jaw pain or tension:	
Neck & Upper Shoulders tight or sore:	
Middle Back:	
Lower Back:	
Arms & shoulders:	
Joints:	
Legs:	
Feet:	

Health History

Please indicate which of the following apply to you:

	NEVER	PAST	NOW		NEVER	PAST	NOW	NOTES:
MENTAL / EMOTIONAL				INFECTIONS				
Emotional Distress				Herpes				
Trauma - emotional				Shingles				
Trauma - physical				Cold sores				
Anxiety				Frequent Colds / infections				
Panic attacks				Glandular Fever (EBV/CMV)				
Road rage				Covid				
Anger / aggression				Tonsillitis,, recurrent				
Depression				Bronchitis				
Grief				Pneumonia				
Assault history				Bronchiectasis				
Sexual abuse				Pseudomonas				
Victim of crime				Molluscum				
Suicidal ideation				Warts				
Compulsive eating				Slap cheek				
Anorexia				School sores				
Bulimia				Chicken pox				
Schizophrenia				Mumps				
Manic Depression				Meningitis				
Bipolar				Clamydia / Gardnerella				
OCD				SKIN				
Perfectionistic				Scaly skin				
Highly competitive				Dry skin				
				Eczema / dermatitis				
VASCULAR SYSTEM				Psoriasis				
Dizziness				Steroid cream use				
Headaches				Burning skin				
Migraines				Rashes				
Blue Sclera (whites of the eyes)				Hives / Urticaria				
Pins and needles				Psoriasis				
Racing heart				Brittle nails				
Irregular heartbeat				Soft / peeling nails				
Heart murmur				White spots on nails				
Palpitations				Folliculitis				
Heart pain								
High Blood Pressure								
Low Blood Pressure				RESPIRATORY				
Abnormal Heart Valve/s				Bronchitis				
Anaemia				Asthma				
Memory issues				Post Nasal Drip				
Arterial Disease				Breathing difficulties				
Valve issues (mitral / tricuspid)				COPD/Chronic Lung Disorder				
High Cholesterol Level				Shortness of breath				
Blood Clots/DVT				Chronic sore throat				
Meniere's / Vertigo				Chronic cough				
Epilepsy / seizures				Constantly clearing throat				
Fainting				Something in throat feeling				
Cold hands/feet								
Clammy hands				GASTRO-INTESTINAL				
				Mouth Ulcers				
METABOLIC				Stomach Ulcers				
Diabetes				Gastritis				
Obesity				History of gastro / Bali belly				
Auto-immune disorder/s				Parasites				
Skin Tags				Coeliac Disease				
Hypothyroid				Irritable Bowel				
Hyperthyroid				Inflammatory bowel disorder				
Hashimotos				Hiatal Hernia				
				Reflux / indigestion				
EYES				Celiac disease				
Cataracts				Gluten sensitivity				
Conjunctivits				Dairy Sensitivity				
Blurred vision				Burning tongue / mouth				
Stigmatism				Mucus in stools				

Floaters			Fatty Liver			
Night blindness / reduced vision			Cirrhosis			
			Gallbladder problem			
HORMONAL			Gall Stones			
Menstrual pain			Diverticular Disease			
Abnormal PAP smear/s			Constipation			
Breast cysts or lumps			Diarrhoea			
Breast tenderness			Encopresis			
Endometriosis			MUSCULOSKELETAL			
Fibroids			Osteoarthritis			
PCOS			Osteoporosis			
Ovarian cysts			Osteopenia			
PMS			Broken Bone/s			
Miscarriage/s			Bone spurs			
Difficulty conceiving			Lipomas			
Heavy menstrual bleeding			Numbness			
Been on the pill or HRT			Paralysis / parasthesia			
Thrush			Tight shoulders			
STD			Fibromyalgia			
Post Natal Depression			Grinding teeth			
Gestational Diabetes			TMJ / jaw issues			
Pre-eclampsia						
Bacterial vaginosis (BV)			OTHER			
Thrush			Autism			
Low libido			Asperger's			
High libido			ADD			
			ADHD			
URINARY TRACT			Focus / Attention Deficit			
Urinary tract infections			Dyspraxia			
Kidney issues			Dyslexia			
Kidney stones						
Prostate issues						
Incontinence						
Erectile difficulties						
Urinary frequency						
Urgent urination						
Painful urination						

Part 2

Quirky Things

Are there any quirky things about you that other people don't seem to have? (eg: can only sleep on one side, one nostril blocks but the other doesn't, headaches looking into the sun, twitches, ticks, mannerisms, throat clearing, can't tell where sounds are coming from, no sense of direction, etc)

Character

Give ten words to describe yourself. (If this is hard, how would others describe you?)

Qualities & Traits

Please highlight as many of these qualities that are like you:

1. Affectionate, Avoids quarrels, Avoids risks, Broods, Caring, Collection, Conscientious, Conservative, Considerate, Conventional, Easy going, Emotional, Family oriented, Fearful, Friendly, Generous, Hesitant, Homely, Honest, Introvert, Kind, Lack of confidence, Lack of motivation, Loving, Loyal, Messy, Mild, Perceptive, Private, Reliable, Reserved, Safe person, Sensitive, Sentimental, Shy, Social, Friendly, Soft, Sympathetic, Thoughtful, Timid, Worrier, Anxious, Compassionate, Amiable.

2. Absentminded, Aggressive, Ambitious, Bossy, Bubbly, Careful, Cautious, Competitive, Confident, Dutiful, Excitable, Extrovert, Follows a routine, Humorous, Impatience, Irritable, Jealous, Materialistic, Optimistic, Outgoing, Passionate, Perfectionist, Planner,

Restless, Romantic, Selfish, Serious, Sincere, Sociable, Strong principled, Strong sense values, Superstitious, Wants to please, Workaholic.

3. Desires solitude, negative attitude, Resentful, Pessimistic.

4. Artistic, Assertive, Changeable, Creative, Discontented, Fault finding, Fears insects and spiders, Fun loving, Independent, Moaning, Moody, Precocious, Stubborn, Temper tantrums, Whining, Intolerant.

If things go wrong and you are maxed out, what do you do? Do you throw things / hit things / withdraw into silence / sulk / erupt in a barrage of swearing ...what happens?

If you could take a week off and money was no issue, what would you do?

If you could change just one thing about yourself, what would it be?

What things do you enjoy doing / what are your hobbies?

Do you carry heartbreak / heartache with you?

Do you carry regret?

Do you carry resentment?

Do you forgive easily or do you 'never forget'?

Have you been badly humiliated in your life?

Have you lived with or been in a relationship with a narcissistic parent / sibling / partner?

Do any of these describe you.	Y/N		Y/N
Have trouble saying no to people		Do you experience road rage often?	
Do you care for others to your own detriment		Do you direct your inside yourself, take the blame, apologize, or take too much responsibility? t?	
Are excessively flattering to others		Are you perfectionistic?	
Are unable to say how you really think or feel?		Are you a workaholic?	
Struggle with low self-esteem		Do you have strong personal boundaries?	
Will avoid conflict at all costs		Do you have social anxiety?	
Often feel taken advantage of		Do you tend to be 'too nice'?	
Are very concerned about fitting in		Do you apologize all the time?	
Find it hard to express your needs			

Part 3

Family History

	What was their WORK / HOBBIES /TOXIC EXPOSURES / TRAUMAS	HEALTH, tendencies, diagnoses (include physical and mental health, ADD, etc)	AGE THEY ARE NOW If passed, how old & what year?
MOTHER			
Maternal G'mother			
Maternal G'father			
Maternal Aunt/s			
Maternal Uncle/s			
FATHER			
Paternal G'mother			
Paternal G'father			
Paternal Aunt/s			
Paternal Uncle/s			
SIBLINGS			
BROTHER/S			
SISTER/S			

Do you know if any of your parents / grandparents / great grandparents had any toxic exposures / infections (eg: TB/tuberculosis, STDs such as gonorrhoea) that you know of?

Your Personal Timeline

Including the health of your parents, this section records all the influences in your life that brought you to this point. If you can speak with your parents about their life before you, it can be a very enlightening conversation. Include health information, infections, medications, procedures, emotions, and life circumstances or exposures.

EMOTIONS are important – make a note of any time peak emotions experienced / suppressed (fears, worries, stressful experiences that were overwhelming, erosive, traumatic, neglectful, abusive etc) and unresolved, they can have an effect on the central nervous system as they are pushed deep within the body where they block function and program you to expect pain or hardship. These are often overlooked as significant initiating traumatic events which go on to lead to dysfunction and disease later in life. These events may include - having parents who were neglectful, fear-inducing, overly judgmental, impossible to please; it may be physical, emotional or sexual abuse, being in an accident, going to hospital alone, being bullied, shamed or deeply embarrassed or humiliated publicly. If you witnessed a traumatic event, accident or violence - **ANYTHING like this please record these incidents below. Childhood experiences are particularly important to note, whether you remember them or were told about them. This information often holds the key to getting well.**

Conception / In-utero exposures / Birth

YOUR FATHER'S HEALTH –

What were the circumstances and health of your dad in the months leading up to your conception?

What work did he do?

Was he a big drinker / smoker / recreational drug taker?

How was his health, did he have any health issues?

What medication was he taking?

Did he have much stress in his life?

Was he exposed to any overt toxins over the course of his work/life? (lead, asbestos, concrete, chemicals, living under powerlines etc)

Did he have any vaccines in the year before your conception?

Had he ever had an STD? (Herpes, warts, chlamydia, gonorrhoea etc)

How was he mentally & emotionally in the leadup to your conception? (eg: Was he happy, contented, or stressed / depressed)

YOUR MOTHER'S HEALTH –

What were the circumstances and health of your dad in the months leading up to your conception?

(EG: what work was she doing, were they together long, were you planned or a surprise, was she healthy and happy or did she have some health challenges/trauma/stressors?)

Had she ever had an STD? (Herpes, warts, chlamydia, gonorrhoea etc)

Was she smoking/drinking much alcohol/recreational drugs?

Medications she was taking before / during pregnancy:

Vaccines taken before/during pregnancy?

IN UTERO –

How was your mum while she was pregnant? How was her health? What was she doing during her pregnancy with you? (Eg: Was she working / stressed / contented / struggling / traumatised / emotional etc...? *Your mother's emotional state during pregnancy is important*).

Was she exposed to cigarette smoke, alcohol, pesticides, environmental agents and medications during pregnancy?

Did she have pre-eclampsia or gestational diabetes?

What is the gap between you and your closest siblings? Was she pregnant again while breastfeeding you?

YOUR BIRTH –

Was your birth NATURAL (vaginal birth) / SURGICAL (cesarian)?

What kind of birth did you have? (eg: spontaneous, induced, cesarean with epidural, cesarean with general anaesthetic?)

How long was the labour?

Did her 'waters' break naturally?

Were there interventions needed?

Were you breast or bottle fed? How long were you breastfed?

Were you given formula? What kind? (soy / goat's / cow's...)

Were you allergic to it?

Did you have any early procedures? (eg: circumcision, heel prick test, neonatal testing, surgery etc)

Did you reach your developmental milestones on time? (fontanelle closing, teething, sitting, crawling, walking, talking etc):

NOTES:

YOUR HEALTH & LIFE STRESSORS TIMELINE

Briefly outline your personal story and timeline: include relationships, home moves, exposures, infections, procedures, stressful experiences, traumas, mouldy environments, water damaged buildings, mercury / toxin exposure, pesticides, jobs, procedures, and life events.

Birth – 2 years old :	3-6 years old :
7-10 years old :	11-13 years old :
14-17 years old :	18-21 years old :
22-25 years old :	26-30 years old :
31-35 years old :	36-40 years old:
41-45 years old :	46-50 years old :
51-60 years old :	60+ :

Part 4

Focus & Attention

Rate for the last month.	Never / Seldom 0	Occasional 1	Often / Quite a bit 2	Very often / frequently 3
1. Sense of restlessness or hyperactivity				
2. Excitable and impulsive, don't think things through before you are acting on an urge.				
3. Fail or struggle to finish things started due to lack of attention and focus				
4. Inattentive, easily distracted, hard to stay focused				
5. Temper outbursts, irritable, short wick, easily angered				
6. Fidgeting, jiggling, can't sit still, always moving a part of your body				
7. Disruptive to others who are trying to focus				
8. Needs must be met immediately or easily frustrated				
9. Easily upset, cry easily or often				
10. Mood changes quickly or drastically, up and down, emotional instability, feel like you're on a rollercoaster				
Tally				
Total out of 30				

Adverse Childhood Events (ACE)

It has been shown that a high score on this survey increases risk of health issues across the board, and the key to getting well must involve trauma recovery to cover the deep drivers of inflammation, addiction, and health impacts. In addition, being raised by parents carrying childhood trauma also increases risk to health and development of children. It is also interesting to consider these questions in light of your grandparents, and its influence on your parent's upbringing. (You don't have to answer this question.)

Prior to your 18th birthday:	YOU		YOUR MUM		YOUR DAD	
	NO	YES = 1	NO	YES = 1	NO	YES = 1
1. Did a parent or other adult in the household often or very often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?						
2. Did a parent or other adult in the household often or very often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?						
3. Did an adult or person at least 5 years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?						
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?						
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?						
6. Were your parents ever separated or divorced?						
7. Was your mother / stepmother / caregiver : Often or very often pushed, grabbed, slapped, or had something thrown at her? &/or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? &/or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?						
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?						
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?						
10. Did a household member go to prison?						
Total : Add up your "Yes" answers: This is your ACE Score out of 10 (Adverse Childhood Experiences)						

Thank you for taking the time to complete this form! ♥😊♥

I know this form is extremely lengthy and detailed, and I'm sure you'll agree the information provided is invaluable. There are things here you may not have realized were important. Be sure to keep a copy for your records.

Thank you for taking the time to complete this form.

I realise that this form is quite lengthy, but the information provided is invaluable in understanding any underlying issues affecting your health.

As part of managing appointments, I need to collect some of your personal scheduling info, however all other files are kept offline and completely safe. Your privacy and the confidentiality is of the highest importance, and are managed safely and securely.

Consent

I give consent for Monica Williams (Naturopathy & Holistic Therapies) to	yes	no
• Collect my personal information for her own clinical notes, and case management. (Stored offline)		
• I consent to my name, phone number and email address to be added to Monica's appointment calendar system (Setmore) and consent to session reminders via SMS or email.		
• I am willing to change my food and lifestyle habits to support my wellness		
• I am willing to take supplements and to support my program as prescribed		
• I am willing to take homeopathics if prescribed		

<ul style="list-style-type: none"> Should my medication change while I am taking supplements, I will contact Monica with the details of my new medications, and make an appointment for a prescription review (this is important) 		
<ul style="list-style-type: none"> I agree to the clinic Cancellation Policy -I understand that I need to give 5 days notice of appointment changes if possible, and missed or late cancellation will be paid for the time held – details here: https://www.healthierbychoice.com.au/cancellation-policy 		

The information I have provided is true and correct.

Name	Signed	Date
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Thank you

Please email in Word.doc format to

Monica.healthierbychoice@gmail.com

*Vaccine Questions – further information

BACKGROUND INFORMATION FOR VACCINES QUESTION - Depending on how, when and how many are given, vaccines can sometimes be the trigger / beginning of issues that develop into a chronic condition over time, depending on the individual’s genetic make-up, concurrent medications, health status at the time and potential inherited susceptibilities. What happened in the days, months and years after a round of vaccines are important to reflect upon, as vaccines have the ability to ‘wake up’ inherited weaknesses.

Common symptoms to think about over the days, weeks, months and years following a vaccine course may include – high fever following, absence of fever in future infections (immune suppression), chronic pain, chronic headaches, chronic inflammations (digestive system, ears, skin, respiratory system, brain/nervous system), SIDS, asthma, eczema, allergies (especially egg, peanut, penicillin), changes in behaviour, mood or personality, epilepsy, spectrum developmental disorders, ADHD, ADD, and type 1 diabetes, for example. Most vaccines contain pathogen-exotoxins in a suspension of penicillin, heavy metals (ie:aluminum), egg albumin and embryonic tissues. These can be triggers for immune reactions that show up days, months or years later. Identifying the trigger makes healing the issue more efficient, so it is important to consider.

Vaccines Schedules over the years (highlight yours : the years you attended school):

Late 1950s – smallpox, DPT (diphtheria, pertussis, tetanus), Polio oral vaccine (there was a batch of polio that was contaminated with the Simian Monkey Virus, later found in carcinogenic tumours)

Late 1960s – smallpox, DPT (diphtheria, pertussis, tetanus), Polio, MMR (measles, mumps, rubella) – mumps added 1967, rubella added 1969, MMR created 1971.

Late 1970s – smallpox vaccination was ceased. Schedule – DPT (diphtheria, pertussis, tetanus, polio, MMR (measles, mumps, rubella)

1980s – Hib added in 1989. Hepatitis B licenced 1981 for high risk groups.

1985-1994 – DPT (diphtheria, pertussis, tetanus), MMR (measles, mumps, rubella), Polio, Hib (Hemophilus influenza type B)

1994-1995 - DPT (diphtheria, pertussis, tetanus), MMR (measles, mumps, rubella), Polio, Hib (Hemophilus influenza type B), Hep B given to babies

1995-2010 – ADDED TO THIS SCHEDULE: chickenpox vaccine 1996, rotavirus 1998-2008 (ceased after 2008 due to increased death in children following the vaccine), hepatitis A 2000, pneumococcal 2001.

2000 – DPT (Diphtheria, pertussis, tetanus), MMR (measles, mumps, rubella), Polio, Hib, Varicella (chicken pox), Hepatitis A & B

2005 – DPT (diphtheria, pertussis, tetanus), MMR (measles, mumps, rubella), Polio, Hib, Hep A & B, Pneumococcal, influenza, Rotavirus

2011 – Above plus New vaccines: meningococcal serogroup B vaccine (2014), Additional recommendations for existing vaccines: HPV (2011 to routinely vaccinate males - giardasil), intranasal influenza vaccine (2018 again recommended)

2020 – DPT (diphtheria, pertussis, tetanus), MMR (measles, mumps, rubella), Polio, Hib, Hep A & B, Pneumococcal, influenza, Rotavirus, Meningococcal (serogroups A, C, W, Y), flu vaccine (influenza), Meningococcal serogroup B.

2021 – add Covid vaccines and boosters

In the 1950s children would receive five shots by 2 years old, but only one combination shot at each visit (not multiples of multiples) The current children’s schedule is for 27 vaccines and boosters by 2 years old using up to six multi-shots per visit. High school vaccines start in year 7 and are usually repeated in year 9. Adult vaccines are recommended over 18 years old (influenza, tetanus DPT, covid etc). It is important to review your own exposure level.