LOUISA CARTER HEALTH

NEW CLIENT FORM
Name:

DOB:

Phone:

Postal Address:

Email:

CONSENT
I use Naturopathic medicine along with Autonomic response testing to provide you with the best treatment option that is indicted for you. I never intend to diagnose in the medical sense but rather gather information to help bring your body back to balance. I do not claim to treat or cure any disease but provide you with alternative support to promote optimal wellbeing. It is ultimately your decision whether to follow through with the protocol we arrive at. I will always provide you with all the necessary information to make informed choices as it is vital that you are the active participant and decision maker in this journey.

I have read and understand the above statement and provide my consent to proceed with the consultation.

Signature: Date:

If you can provide as much information as you can in the following form it will help me to establish the best understanding of your current health status and in turn provide the most efficient assistance in consultation with you. Much appreciated.

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Establishing your Health Goals:
Health goals: What are you hoping to achieve in consultation with me?
List, in order of importance, your major health concerns/what you wish us to address today:

Please write down a general timeline of your **health history**. Starting from childhood, include all major and significant illnesses, trauma (emotional and physical) injuries, operations, hospitalisations, and other medical diagnoses you think I should know about:

Illness, operation, trauma etc.:
Year
Details/notes

Please list your **current health care professionals:**

Practitioner/Doctor
Modality
Clinic name
Phone number

Practitioner/Doctor
Modality
Clinic name
Phone number

Practitioner/Doctor
Modality
Clinic name
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What other treatments have you already tried? Massage, surgery, homeopathy, nutrition, acupuncture, etc.?

Current Medications: (include all prescription and over-the-counter medications; don't forget birth control, hormones, etc.) Medication Dose/Frequency for how long? For what reason?

Medication
Dose/frequency
For how long
For what reason

Medication
Dose/frequency
For how long
For what reason

Medication
Dose/frequency
For how long
For what reason

Please also explain your history of drug and antibiotic use? How many times have you taken antibiotics in your life and for what conditions? Including childhood. Please note if any other medications have been taken for certain periods: pill, anti-depressants, paracetamol.

Current Supplements: (include all vitamins, herbs, homeopathy, or other supplements)

Supplement
Brand
Dose/frequency
For how long
For what reason

Supplement
Brand
Dose/frequency
For how long
For what reason

Supplement
Brand
Dose/frequency
For how long
For what reason

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When did you last have a **blood test** done?
Was there anything out of the ordinary found? If appropriate, please send a copy of results.

Family history:

Family History: Please describe what conditions, illnesses or symptoms run in your family. Include your PARENTS, SIBLINGS, CHILDREN, or GRANDPARENTS:

- Blood pressure
- Heart disease
- Heart attack
- Stroke
- Diabetes
- High cholesterol
- Autoimmune
- Thyroid disease
- Obesity
- Osteoporosis
- Arthritis
- Alcoholism
- Drug addiction
- Anxiety
- Depression
- Allergies
- Asthma
- Cancer

Other:

If deceased, please list age & cause of death:

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Food and Diet:

Do you have any dietary restrictions or follow any specific dietary plan?

Please give an example of what your daily food and drink routine and consumption looks like?

First thing in the morning

Breakfast

Mid-morning

Lunch

Mid afternoon

Dinner

Dessert

Snacks:

Do any of these eating habits apply to you?

- Skip breakfast
- 3 meals a day
- 2 meals a day
- Graze (small, frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Crave sweets
- Crave salt

Water:

How much water do you drink daily (including herbal teas)?

Is your water purified (what type of purifier?) tap or bottled?

Caffeine:

How much caffeine do you drink daily or weekly (including coffee, energy drinks, black and green tea and coke)?

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Digestion:

How often do you go to the toilet for a bowel motion (daily, weekly)?

Do you experience diarrhea and/or Constipation?

Have you ever noticed any of the following in your stool (circle)?

- Blood
- Mucous
- Oil
- Undigested food

How would you describe the colour of the stool (circle)?

- Pale brown
- Mid brown
- Dark brown
- Black
- Changeable
- Yellow brown
- Orangey brown
- Green
- Other _____

How would you describe the consistency (circle)?

- Hard
- Soft
- Well formed
- Unformed, loose
- Watery
- Pellet like
- Narrow and long
- Thin
- Other_____

How would you describe the odor (circle)?

- Normal
- Worse than normal
- Really unpleasant
- Other _____

Do you experience any of the following? (If yes, please provide more information)

- Bloating, burping or belching
- Abdominal pain or cramps
- Any trapped wind or flatulence
- Acid reflux, heartburn, indigestion

Stress:

Stress level (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

What are your major sources of stress? _____

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What is your current self-care and stress management routine? Do you feel this is enough?

Sleep and energy:

Sleep: How long do you sleep each night? _____

Do you have difficulty falling asleep? _____

Do you wake during the night?

Do you wake feeling refreshed, if no then how? _____

General Energy level (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

What would you consider your worst time of day?

What would you consider your best time of day?

What improves your energy levels?

What reduces your energy levels?

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Female reproductive system:

Circle which best describes your current menstrual status (circle)?

- Pre menopause (before menopause; having periods)
- Amenorrhea (before menopause, but not having periods)
- Peri menopause/transition towards menopause (I have seen changes in my period and think menopause is coming soon, but I have not gone 12 months in a row without a period)
- Post menopause (I have not had a period in 12 months)

If you are still menstruating:

Are your periods usually?

- Regular
- Irregular

How many days between periods? _____
How many days do your period last? _____
Are your periods painful? _____
Do you have any clotting or heavy periods?
Do you have spotting or bleeding between periods? _____
Do you experience any premenstrual symptoms such as: (please circle)_____

- Anxiety
- Irritability
- mood swings
- nervous tension
- Increased appetite
- Headache
- Fatigue
- dizziness or fainting
- palpitations
- cravings
- Depression
- Crying
- Forgetfulness
- Confusion
- insomnia
- Weight gain
- swollen extremities
- breast tenderness
- abdominal bloating
- Acne
- Oily skin
- dry skin

Other:

If you are no longer menstruating:

Age at onset of Menopause: _____
Was your menopause: Spontaneous/Natural Surgical/After a hysterectomy Do you use or have you used Hormone Replacement Therapy?
_____

Do you suffer from any Menopausal symptoms including any of the following (please circle)?

- hot flushes
- vaginal dryness
- mood swings
- irritability
- depression
- poor memory
- concentration
- poor sleep
- night sweats
- loss of libido
- arthritic symptoms

Please provide any further information on your personal symptoms and experience:

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Immune System:
How often do you get a cold or flu?

Do you get any recurring infections (chest, urinary, tonsillitis) now or in the past?

Vaccination:
Did you have childhood vaccinations? _____

List any adult vaccinations? (e.g.: flu shots, swine flu, travel shots)

Mental/emotional:
Do you experience any of the following (please circle)?

- Anxiety
- Depression
- Bipolar disorder
- Suicidal thoughts
- Anger
- Fearful
- Panic attacks
- Mood swings
- Poor memory
- Post traumatic stress
- Other:

Nervous system:
Do you experience any of the following (please circle)

- Tingling/numbness
- Paralysis
- Seizures
- Sciatica
- Carpel tunnel syndrome
- Insomnia
- Tremors
- Other:_____

Health Habits:
Tobacco: Current? _____ Past? _____ Amount per day: _____ Since when?_____

Does anyone smoke in your household? _____

Alcohol: Number of drinks per day: _____ what do you drink? _____

Recreational Drugs? _____

Exercise:
Do you exercise? _____
What type of exercise do you do? _____
How often do you exercise? _____
For how long do you exercise? _____

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Dental history:
Please indicate how many mercury amalgam (black/silver) fillings you are aware you currently have?

Do you have any of the following (circle):?

- Crowns
- Root canals
- Dental implants
- Other dental structures (braces, plates, bridges etc.)

Have you had any fillings removed in the past? If so, how many and when were they removed?

Travel history:
Have you spent time in any developing countries? Please provide details.

Have you contracted any tropical illnesses or infections while there, including Diarrhea and vomiting?

Are you aware if you have ever been bitten by ticks or any other insect bites where you've reacted to the bites?

Heavy metal exposure:
Please mention any significant exposure you may be aware of or suspect:

- Mental dust (lead, mercury, iron etc.)
- Industrial poisons
- Chemicals
- Paints
- Pesticides
- Herbicides
- Fertilizers or asbestos
- Other:

Do you have any **scars, tattoos or metal plate, pins or implants**?
Location:
How obtained/how long have you had them?

Again, in a few words, what is the biggest thing you are hoping to get out of consulting with Louisa?

Thank you for providing me with this information.
Please be sure to send it back to me prior to our consultation.
I am looking forward to working with you.
Louisa
Are you happy to Subscribe to Louisa Carter Health updates and inspiration Yes NO

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