Southside
Clinic

Pre Treatment Questionnaire – For treatment with Dr Andrea Robertson

Patient Profile

Please complete the following form thoroughly to assist Dr Andrea in her diagnosis and treatment. This will become a part of your confidential medical record and will not be shared unless you authorise its release.
Please print clearly.

Date:		
Title	First Name	Surname
Date of Birth		
Address		
Mobile	Home Phone	Work Phone
Email □ Tick if you would prefer not to receive our emails		
Occupation		
Height	Weight	
Emergency Contract Name:	Phone	Relationship
Are you entitled to any concessions (Pensioner/Health Care Card)?		
Please name any family members who also come to Southside Clinic:		
GP Name	Suburb	

How did you hear about Dr Andrea Robertson?

□ Doctor Referral
(Name): ___________________________________
□ Other Health Practitioner
(Name): ___________________________________
□ Yellow Pages Print
□ Other ___________________________________

□ Friend / word of mouth / existing patient
(Name): ______________________________
Internet
□ Google Search Engine
□ Natural Therapy Pages
□ other__________________________________

Current Concerns

Please list your main concerns and reasons for this appointment

1. ____

2. ____

3. ____

How do you hope your life will change as a result of this consultation and treatment?

Have you had any previous or current treatment for the above concerns? If yes, please list.

Are you currently under treatment for any other condition, medical or other?

How would you describe your general health?

Detailed Past Medical History

Please outline your past medical history on the timeline below, including: health concerns, illnesses, accidents, toxic exposure, frequent medication use (ie antibiotics), any periods of high stress, and anything else you may think is relevant.

In Utero: did you mother have any health concerns while she was pregnant with you?
Labour: did your mother have any complications during your birth?
0-5 years of age:

5-10 years of age:

10-20 years of age:

20-30 years of age:

30-40 years of age:

40+ years of age:

Symptoms Questionnaire

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if you have never experienced this symptom.

Gastro-intestinal	Respiratory	Skin	Cardiovascular
☐ Bloating ☐ Flatulence ☐ Reflux/Heartburn ☐ Indigestion ☐ Nausea ☐ Abdominal pain ☐ Constipation ☐ Diarrhoea ☐ Food intolerances ☐ Blood in stools ☐ Mucus in stools ☐ Strain to pass stools ☐ Feels incomplete after passing stools ☐ Frequency of passing stools…………	☐ Persistent cough ☐ Sneezing, wheezing ☐ Post nasal drip ☐ Ear infections ☐ Itchy eyes, ears, nose, throat ☐ Sore throat	☐ Slow wound healing ☐ Acne ☐ Psoriasis ☐ Dry, flaky skin ☐ Oily skin ☐ Eczema / skin rashes	☐ Excessive fatigue ☐ Shortness of breath ☐ Easy bruising or bleeding ☐ Palpitations ☐ Dizziness ☐ Varicose veins ☐ High blood pressure ☐ High cholesterol
Immune/Lymphatic	**Sleep**	**Emotional**	**Musculoskeletal**
☐ Poor immunity ☐ Recurrent cold / flu ☐ Hayfever / sinusitis ☐ Fluid retention ☐ Cold sores ☐ Inflamed / bleeding gums ☐ Auto-immune disease ☐ Cancer	☐ Insomnia ☐ Difficulty falling asleep ☐ Waking during night What time?_______________ ☐ Waking un-refreshed ☐ Regular dreaming ☐ Night sweats ☐ Dream at night Time go to bed____________ Time wake up_____________	☐ Depression ☐ Anxiety ☐ Mood swings ☐ Poor memory ☐ High stress levels ☐ Feelings of being overwhelmed or unable to cope	☐ Headaches ☐ Migraines ☐ Muscle aches or cramps ☐ Joint pain ☐ Restless legs ☐ Muscle weakness
Endocrine	**Urinary / Renal**	**Male hormone balance**	**Female hormone balance**
☐ Fatigue / poor energy ☐ Recent weight gain ☐ Heat / cold intolerance ☐ Hair falling out ☐ Abdominal weight gain ☐ Thyroid disorder	☐ Excessive urination ☐ Frequent urination ☐ Pain with urination ☐ Incontinence ☐ Bloody, cloudy or smelly urine☐ Urinary tract infection	☐ Low libido ☐ Difficulty starting urine flow ☐ Premature ejaculation ☐ Difficulty maintaining erection ☐ Genital rash or irritation ☐ Painful testicles	☐ Hot flushes ☐ Night sweats ☐ Change in menstrual cycle ☐ Dry hair, skin or vagina ☐ Low libido ☐ Excessive libido ☐ Bleeding after intercourse ☐ Infertility ☐ Miscarriage
Pre-menstrual symptoms (women only)	**Menstrual symptoms (women only)**	**Sexual Health**	**Lifestyle**
☐ Depressed or teary ☐ Anxious or irritable ☐ Feeling aggressive or angry	☐ Long intervals between cycles ☐ Cycles longer than 32 days	☐ Thrush ☐ Genital herpes ☐ Sexually transmitted disease ☐ Irregular pap smear	☐ Smoker _____ / day ☐ Passive smoker ☐ Coffee _______/ day ☐ Tea _______/ day ☐ Alcohol _____ /week

☐ Breast tenderness ☐ Food cravings ☐ Fluid retention/bloating ☐ Back pain ☐ Abdominal pain ☐ Headaches or migraines	☐ Cycles shorter than 24 days ☐ Heavy blood flow or flooding ☐ Passing of blood clots ☐ Very light blood flow ☐ Spotting before or after bleed ☐ Period pain	☐ Painful intercourse ☐ Burning or itching pain on genitals	☐ Water ______/day Recreational drugs ☐ Bleach and ammonia use (cleaning) ☐ Excessive plane travel ☐ Radiation exposure ☐ Pesticide / herbicide exposure

Food Intolerances

Tick any food sensitivities / intolerances you have:

- Dairy ☐
- Wheat ☐
- Gluten ☐
- Corn ☐
- Sugar ☐
- Eggs ☐
- Citrus ☐
- Coffee ☐
- Alcohol ☐
- Fatty foods ☐
- Salty foods ☐
- Spicy foods ☐
- Meat ☐
- Other ☐ ____________________________
- Other ☐ ____________________________

Environmental sensitivities and allergies

Tick any allergies or sensitivities you have:

- Odors ☐
- Smoke ☐
- Soaps ☐
- Fumes ☐
- Perfume ☐
- Dust ☐
- Grasses ☐
- Pollen ☐
- Mould ☐
- Medications ☐ ____________________________
- Supplements ☐ ____________________________

Current Medications

Please itemise all medications you are currently using or have recently used. Please be sure to include all over the counter medications as well.

Name of medication	Reason for use	Dose	For how long have you been taking?	Prescribing Doctor/Self?

Current Supplements

Please list all vitamins, minerals, herbs and other natural products you are currently using or have recently used.

Name of natural product	Reason for use	Dose	For how long have you been taking?	Prescribing Practitioner/Self?

Lifestyle Factors

Exercise

Specify how many days per week, and number of minutes per session

Exercise	Days/Week	Minutes/Session	Exercise	Days/Week	Minutes/Session
Walk			Dance		
Run			Yoga		
Bike			Stretching		
Group Fitness class					
Weights					

Hobbies / Activities for Pleasure / Relaxation

Specify how many times per week or month

Activity	Times/Week	Times/Month

Stress

On a scale of 1-10 (10 being the worst you can imagine), how would you rate your stress?

Minor 1 2 3 4 5 6 7 8 9 10 Severe

Previous investigations / tests / operations / hospitalisations? Please list.

Type of Surgery/Investigation	Date	Reason	Results

Self & Family Medical History

Self and family - please tick

	Self	Mother's side	Father's side
Allergies			
Alzheimer's Disease			
Arthritis			
Asthma			
Autoimmune disease			
Bowel disorder			
Cancer			
Cardiovascular disease			
Depression			
Diabetes			
Digestive Disorders			
Eating Disorder			
Eczema or Psoriasis			
Epilepsy			
Endometriosis			
Fibroids			
Gastroenteritis/Giardia etc			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Hysterectomy			
Kidney Disease			
Liver Disease			
Mental Health disorder			

Migraine			
Obesity			
Osteoporosis			
Sexually transmitted disease			
Stomach Ulcer			
Stroke			
Thyroid disease (low or high)			
Other			

3 Day Diet Diary

DAY 1	DAY 2	DAY 3
Breakfast	Breakfast	Breakfast
Morning snack	Morning snack	Morning snack
Lunch	Lunch	Lunch
Afternoon snacks	Afternoon snacks	Afternoon snacks
Dinner	Dinner	Dinner
Other snacks	Other snacks	Other snacks

In general, how often do you eat out?

In general, how often to you eat fast food?

Do you crave any foods?