



HEALTH QUESTIONNAIRE

Answering these questions is completely optional, but will assist me in giving the best possible care, and help with on-going research into the treatment of disease and restoration of health. All information will be held in the strictest confidence and used outside RETURN TO STILLNESS only with your express permission. This questionnaire is designed for a variety of health challenges, and therefore some areas may not be applicable to you. Please complete all sections relevant to you in any way. Please answer questions as accurately as possible. If you can't remember all details, please give the information you can remember.

PERSONAL DETAILS:

Surname: _____

Given Names: _____

Address: _____

State _____ Post/Zip Code _____ Country _____

Phone: _____ Fax: _____

Mobile: _____ Email: _____

Date of Birth: ____/____/____ Place of Birth: _____

When did you move to Australia? (if applicable) _____

Marital Status: _____ Name of Spouse/Partner: _____

Occupation [if retired, please show previous occupation(s)] _____

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DIAGNOSIS/MAIN CONDITION:

When were you first diagnosed with your main condition? _____

What was the diagnosis? _____

Who was the doctor/practitioner who made the diagnosis? _____

Who is your current doctor/GP? _____

Who is your current specialist? _____

What symptoms prompted you to go to your doctor for investigations? _____

When did these symptoms first become noticeable to you? _____

GENERAL HEALTH

Height _____ Weight _____ Body type _____

Are you allergic to anything (food, drugs, plants, insect bites, etc.)? Yes/No Please give details:

What other health conditions concern you now (eg. arthritis, hypertension, diabetes, etc.)? Please include everything, no matter how trivial it may seem. Please include the time when these health conditions first occurred.

Please describe any other symptoms in as much detail as possible (e.g. type of symptom, where, when, what makes it worse/better, etc). Include all symptoms, even if they seem irrelevant; e.g. headaches, oedema, sore toe, etc. Please include the time when these symptoms first occurred.

Do you feel depressed some or all the time? Describe: _____

Do you smoke cigarettes? YES / NO How many per day? _____

How long have you been smoking? _____ When did you stop? _____

Do you drink alcohol? YES / NO If so, how many drinks per day/week/month? _____

Do you have a bowel motion every day? _____

Do you have diarrhoea and/or constipation? _____

Please circle any of the following skin conditions you have experienced:

Eczema Dermatitis Acne (persistent/intermittent) Skin changes in last 5 yrs

Please give details of any regular exercise you undertake:

Do you meditate or use any form of relaxation technique? Details: _____

Do you sleep well? Describe:

HEALTH HISTORY

Please list all serious disorders you have had, including childhood and adult illnesses (e.g. mumps, measles, pleurisy, etc). If you are not certain if the disease is serious, please include it.

Disorder	Age (approx.)	Disorder	Age (approx.)

Please list all surgical procedures and type of anaesthetic:

Surgery	When (approx.)	Anaesthetic (General/Local/Spinal)

Please give details of any accidents you have had (motor cars/trucks, work related, sporting, childhood) even if they seem irrelevant.

Accident	When?	Injuries

Did you ever suffer from "growing pains" (aching limbs or joints) as a child? YES/NO

Did you ever suffer from frequent headaches? YES/NO If so, at what age(s)? _____

Have you ever had "cracking joints"? YES/NO If so, when? _____

PERSONAL HISTORY

Do you have children? YES/NO If so, how many? _____

Ages of children _____ Number of pregnancies? _____

Are your parents still alive? Father YES / NO Mother YES / NO

Please describe your relationship with your Father as a child. Please be as frank as possible.

Did this change? _____ If so, how? _____

Please describe your relationship with your Mother as a child. Please be as frank as possible:

Did this change? _____ If so, how? _____

Was either parent absent for significant periods of time? (months/years) _____

Details: _____

Please show the number of siblings in each group below:

Older brothers _____ Older sisters _____ Younger brothers _____ Younger sisters _____

What sort of relationship did you have with your siblings when young? _____

Has this relationship changed? _____ How? _____

Is there any family history of your main condition? Please give any information you may think is relevant. _____

HAVE YOU EVER:

Been divorced? YES/NO Widowed? YES/NO Re-married? YES/NO

Been retrenched or sacked? YES/NO Details: _____

Lost a child/sibling/friend through illness, accident or miscarriage? YES/NO

Details: _____

Moved house in difficult circumstances? YES/NO When? _____

Details: _____

Moved interstate or to a new country? YES/NO When? _____

Spent time in work which was not suitable for you for any reason? Yes/No

Details: _____

Spent time in the armed forces? YES/NO When? _____

Details: _____

Been in contact with toxic chemicals such as Agent Orange, Carbon tetrachloride, Deildrin or others? YES/NO Please give details if possible _____

Been in contact with asbestos? YES/NO Details: _____

Sought counselling or psychiatric help for any reason? YES/NO

Details: _____

Did this help you? _____

Tried non-medical therapies for any ailment? YES/NO

Details: _____

Ailment

Therapy

Helpful?

<u>Ailment</u>	<u>Therapy</u>	<u>Helpful?</u>

DIET

Please give details of your food consumption on an "average" day, and be as specific as you can, for e.g. 'cornflakes', or 'rolled oats' **instead of 'cereal'**. (If there are significant variations, please attach a separate sheet detailing those.)

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

TEA (number of cups daily)

COFFEE (number of cups daily):

SOFT DRINKS/CORDIAL (number of GLASSES daily):

WATER (number of GLASSES or LITRES daily):

CRAVINGS:

The following questions are grouped into different symptom areas. Please complete only the sections relevant to you in any way.

If you experience any of the following symptoms, please tick and give details where appropriate.

NEUROLOGICAL DISORDERS ONLY

	<u>MILD</u>	<u>MODERATE</u>	<u>SEVERE</u>	
Tremor at rest:	___	___	___	Where is the tremor? _____
Tremor with action:	___	___	___	Where? _____
Muscle rigidity:	___	___	___	Where? _____

Difficult/slow movements				Stooped posture
Difficulty in walking				Poor balance
Tingling or numbness Where?				Clumsiness
Fixed facial expression				"Freezing" (unable to move)
Speech changes				Difficulty turning in bed
Muscle weakness				Fatigue
Sleep disturbances				Sleepy during the day
Dizziness				
Difficulty doing more than one thing at a time?				
Pain?				If so, where and when?
Difficulty with buttons/				laces/ or other fine movements?
Incontinence/Frequency/Urgency				
Shortness of breath				Palpitations
Acid reflux/belching				Hot flushes/sweating
Skin changes				Are you confused sometimes?

Please list any other symptoms that you have _____

If you experience any of the following symptoms, please tick and give details where relevant.

MALE

Impotence _____ Reduced libido _____
Urination problems _____ Urinary frequency at night _____
PSA if known _____
Other: _____

FEMALE

Painful menstruation _____
Irregular menstruation _____
Premenstrual tension _____
Other: _____

DIGESTIVE

If you experience any of the following, please provide details.
Reactions after eating certain foods? _____
Feel nauseous or bloated after eating any foods? _____

Open your bowels every day? YES/NO _____
Diarrhea? _____
Fluctuate between diarrhea and constipation? _____
Indigestion? _____
Discomfort or pain? _____
Reflux? _____
Other: _____

Please attach or include information regarding TESTS you have had. (E.g. MRI, blood pressure reading, blood cholesterol results, thyroid function.)

Please feel free to provide additional information that may help in planning your return to health.

Thankyou for completing this questionnaire. Once again, I assure you that all information will be held in the strictest confidence. Some details may be used for statistical analysis without any individual answers being revealed. Should RETURN TO STILLNESS need to use individual information for any reason, your permission will be requested before the information is used. Your name and identifying details will never be used outside RETURN TO STILLNESS unless you give express permission.