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Karuna Health Care

ADULT HISTORY RECORD

Allow 20 minutes to complete this form (4 pages).

Date:

Name: Age: Sex: DOB:

Address: Postcode:

Phone: Email:

Occupation: Marital Status: Children:

Health Fund:

GP's Name & Address:

Specialist's Name & Address:

Please complete the following pages **in as much detail as much as you can**. Details about your symptoms provide information to more accurately assess you. No detail is too small!

What would you like to have treated? List your complaints in order of importance:

1.
2.
3.
4.
5.

Please list your symptoms in order of severity:

1.
2.
3.
4.
5.

How and when did your symptoms start?

Do you have any other health problems? If yes, please list:

What medical treatment(s) have you had?

What natural therapies have you used so far?

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Which of these treatments have you found to be the most effective?

Current supplements – vitamins, minerals etc?

Current prescribed medications?

Anything else you would like to mention?

General health & lifestyle information.

Please rate your energy levels **(circle)** [no energy] 0 1 2 3 4 5 6 7 8 9 10 [high energy]

Symptoms during sleep?

☐ snoring ☐ mouth breathing ☐ restlessness ☐ sleepwalking
☐ night sweats ☐ perspiration ☐ nightmares

Any other symptoms during sleep?

Regular wakefulness? Time of waking?

Reason for waking?

What position do you like to sleep in?

How do you feel in the morning after waking?

Any amalgams? (silver fillings)

Do you have any drug, environmental, food, or other allergies? Please state:

How do you tolerate hot weather? Cold weather?

Does any type of weather affect your symptoms? Please describe

What season do you feel most comfortable in?

How much alcohol do you drink / week? What type?

What type of exercise do you do? How often?

Digestion

Do you suffer:

☐ Pain ☐ Wind ☐ Bloating ☐ Indigestion ☐ Burping
☐ Diarrhoea ☐ Constipation

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When do you get these symptoms in relation to eating? Before, during or afterwards?

What are your favorite foods?

Do you have any food cravings? If so, what are they and the time of day that you most crave them?

List any foods that you really dislike

List any foods that disagree with you, even if you like them

Mental / Emotional

Do you have any fears of phobias? (e.g. heights, spiders, tunnels, crowds, snakes, the dark, public speaking, thunderstorms)

If anxious, what do you worry about?

Is there anything else about yourself, which you feel impedes your ability to enjoy life, that you would like to change?

Medical History

An accurate timeline of your medical history is important. Please include all traumas (including around your birth), stressful events, surgeries, hospitalisations, and courses of antibiotics.

0-5 yrs:

5-10 yrs:

10-20 yrs:

20-30 yrs:

30-40 yrs:

40-50 yrs:

50 + yrs:

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Family History

Please describe **all** known diseases of the following family members e.g. heart disease, high blood pressure, diabetes, cancer, skin problems (e.g. psoriasis), TB, allergies, mental illness, alcoholism.

Mother

Father

Immediate family (brothers, sisters, grandparents, aunts and uncles)

Please list medical tests you have had:

TYPE OF TEST	DATE	REASON	RESULT
Blood Test(s)			
X Ray(s)			
CT Scan			
Ultrasound			
Hearing Test			
Other			

Anything else you would like to mention?

BEFORE COMING TO CLINIC:

- Please do not wear perfume.
- If you would like to know your health fund rebate amount, please check with your fund prior to your consultation.

Where did you hear about the clinic?

☐ I agree to the Terms and Conditions, found in the **Policies** section on the Booking page at https://karunahealthcare.com.au/book-appointment/