Sundardas Naturopathic Clinic
Your Natural Partner in Wellness

FOR OFFICIAL USE

REF. NO.

_____

DATE

_____

PERSONAL PARTICULARS

BLOOD TYPE _____

Please print the following information. Your answers are important for our records and your health.

Surname (Mr/Ms/Mrs/Mdm/Dr) _____ Given Name _____

Age _____ D.O.B _____ IC/Passport No. _____ Occupation _____

☐ Male ☐ Female | ☐ Single ☐ Married ☐ Widowed ☐ Divorced No. of Children _____

Home Address _____

_____

_____

Tel. (H) _____ (M) _____ (O) _____

Office Address _____

_____

_____

Email _____ Referred by _____

If you are completing this form for the patient, what is your relationship to the patient and your name?

_____

A. WHAT ARE YOUR SPECIFIC COMPLAINTS? LIST FROM MOST TO LEAST IMPORTANT

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

• WHEN did you first experience the condition for which you are seeking help? Date _____

• DO YOU KNOW HOW THE SYMPTOMS STARTED?

Fall/Accident, give details _____

Mental/Emotional stress _____

Others, give details _____

• WHAT do you think is the cause of your condition? _____

• WHAT aspect of your condition concerns you the most? _____

B. ARE YOU CURRENTLY TAKING ANY MEDICATION? **NO/YES** (Give details)

Name _____ Name _____

Quantity _____ Quantity _____

Reasons _____ Reasons _____

C. DO YOU HAVE ANY ALLERGIES? **NO/YES** *(Give details)*

_____

D. HAVE YOU HAD PREVIOUS SURGERY? **NO/YES** *(Give details)*

_____

E. HAVE YOU HAD PAST DISEASE/TRAUMA/ILLNESS/ACCIDENTS? **NO/YES** (Give details)

_____

F. HAVE YOU EVER HAD A VACCINATION? **NO/YES** (Give details)

_____

G. DO YOU HAVE MERCURY FILLINGS? **NO/YES**

• Do you have any teeth with root canals? **NO/YES**

• (For children with ADD/ADHD/Autism only)
Does the mother of the child have any dental amalgam in the teeth? **NO/YES**

• If you are required to remove your silvery amalgam fillings in your teeth and replace them, would you? NO/YES

Would you like to be on our mailing list? **NO/YES**

FOR OFFICIAL USE

H. HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE PAST 10 YEARS? YES/NO *(Please underline)*

i) Antiboitics ii) Steroids iii) Birth control pills

I. DO YOU EXPERIENCE FATIGUE? NO/YES

If yes, *(Please underline)*

- Do you feel tired/sleepy 2 to 3 hourss after a meal? **NO/YES**
- Do you become nervous, irritable, edgy when you miss a meal? **NO/YES**
- Do you get a headache if you miss a meal? **NO/YES**
- Do you crave sugar-rich foods if you miss a meal? **NO/YES**

J. PLEASE UST A SAMPLE OF WHAT YOU TYP(CALLY EAT AND DRINK FOR 3 DAYS.

	DAY 1	DAY 2	DAY 3
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Dinner	_____	_____	_____
Snack	_____	_____	_____

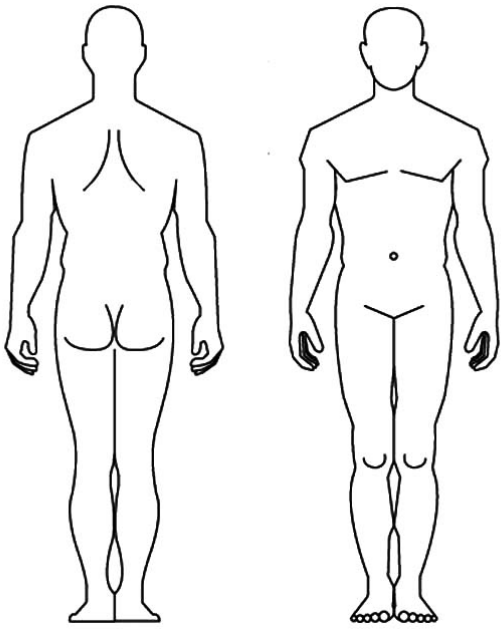
• If you are required to change your diet drastically, would you? **NO/YES**

K. HAVE YOU BEEN EXPOSED TO THE FOLLOWING SITUATIONS:

• Renovations or buildings being painted? **NO/YES**

• Travelling in Asia? **NO/YES**

L. PLEASE MARK AN "X" ON THE DIAGRAM FOR THE PAIN SPOTS ON YOUR BODY



M. WOMEN ONLY

Are you pregnant? **NO/YES** If yes, what's your expected delivery date _____

N. SIGNATURE _____

Dear Client,

In order to determine the nature of testing we need to do, we would appreciate you filling in the following. The more completely you complete the forms, the more quickly and accurately we can tailor the right programme for you.

** Mark "1" for conditions that are frequent*
** Mark "2" for conditions that are mild*
** Leave blank if conditions do not apply to you*

Renal
___ Standing too quickly makes pulse roar in ears
___ Standing too quickly causes faintness, dizziness
___ Wakes up at night to urinate
___ Frequent flushing or any flushes
___ Water retention with. change of weatha
___ Moderate high blood pressure, craves fats
___ Moderate low blood pressure, crave sweets
___ Frequent thirst
___ Craving for salt
___ Urine always light coloured
___ Urine usually darker

Lower Urinary Tract
___ Frequent urination, small amounts
___ Infrequent urination, copious
___ Sometimes dribbles urine afterwards
___ Frequent bladder infections
___ Demanding and sudden need to urinate
___ Mucus in urine
___ Dull ache after urination

Reproductive
___ Sweat freely with strong scent
___ Oily skin, facial acne
___ Dry skin, cold hands and feet
___ Period late with attitude change
___ Tried but could not handle birth control pills
___ Frequent Candida type infections

Women
___ Cycle more than 28 days
___ Cycle less than 28 days
___ Water retention before menses, hips/breasts swollen
___ Water retention before menses, feet/hands swollen
___ Usually craves fats/protein before menses
___ Usually craves sweets before menses
___ Sides of breasts tender before menses
___ Misses some periods
___ Menses slow starting with cramps
___ Palpitation before menses
___ Menstruation lengthy, frequent cramps
___ Menstruation short, defined, few cramps
___ Frequent Class II Pap Smears
___ History of PID, Cervicitis
___ Miscarriages, problem pregnancy
___ Period early with attitude change

Men
___ Frequent alcohol user
___ Pain or ache after orgasm
___ Benign prostatic hypertrophy (prostate)

Upper Gastro-intestinal Tract
___ Sometimes nauseated in the mornings
___ Sometimes nauseated in the evenings
___ Sometimes excess salivation
___ Mouth frequently too dry
___ Duodenal ulcer
___ Stomach ulcer
___ Sometimes foul burps
___ Butterllies in stomach
___ Seldom eats breakfast
___ Often don't finish meals
___ Often eat to calm down
___ Receding gums
___ More than one alcoholic drink per day
___ Frequent poor appetite
___ Strong, demanding hunger
___ Bitter taste in the morning
___ "Dragon Breath" in the morning
___ Acid indigestion at night
___ Frequent mouth or cold sores
___ Sometimes difficulty in swallowing
___ Indigestion after eating

Lower Gatstro-intestinal Tract
__ Stools loose with gas
__ Constipation with gas
__ Frequent constipation
__ Digestion unusually rapid
__ Loose stools when tired/stressed
__ Light coloured, hard stools
__ Dark, soft stools
__ Quick defecation after eating
__ Intestines often bloated
__ Constipation with hemorrhoids
__ Water retention on before menses
__ Constipation w/hard, marbly stools
__ Constipation w/futly formed stools
__ Constipation alternated with diarrhea
__ Frequent need for laxative
__ Tongue often coated

Liver
__ Dry, even scaly skin
__ Moist, sometimes oily skin
__ Hives from food or drugs
__ Hay fever or asthma
__ Craves protein
__ Craves fruits or sweets
__ Frequent trouble digesting fats
__ Acne on face AND buttocks
__ Seems to have low blood sugar
__ Had hepatitis in the past
__ Frequent use of alcohol
__ Works with solvents
__ Psoriasis, Eczema or dermatitis
__ Frequent minor illness
__ Sweat
__ Do not sweat when sick

Respiratory

___ Shortness of breath when standing or walking
___ Tobacco smoker
___ Easy coughing of mucus
___ Difficulty swalling mucus
___ Rapid, shallow breather
___ Sometimes wake up choking/gasping
___ Yawns frequently
___ Sometimes hyperventilates
___ Frequent chest colds

Cardiovascular

___ Slow, strong pulse
___ Fast, light pulse
___ Frequent physical activity
___ Warm bodied
___ Cold bodied
___ Sometimes dizzy or faint
___ Hands warm and sweaty
___ Hands cold, clammy or dry
___ Palpitation either as an adolescent or before menses
___ Hypertension, responds to diuretics
___ Hypertension, does not respond to diuretics

Lympathic

___ Recuperates quickly if ill
___ Recuperates slow if ill
___ Injuries heal quickly
___ Injuries heal slowly
___ Eczema, dermatitis
___ Asthma or hay fever
___ Arthritis or rheumatism
___ Digests fats easily
___ Digests fats poorly

Skin

___ Skin eruption are supedicial. come to a head
___ Skin eruptions deep. do not come to a head
___ Skin on trunk of body is dry
___ Oily scalp or hair
___ Dry scalp or hair
___ Cracks, fissures on heel, feet slow healing

Mucus

___ Sores/cracks on mouth. anus or vagina
___ Lips often dry or chapped
___ Food often causes intestinal pain wnen passing through
___ Gets sore throat easily

General

___ Use aluminium cookware
___ Awakens and can't go back to steep
___ Bad dreams
___ Blurred vision
___ Brown spots. bronzing of skin
___ Bruises easily
___ Can't gain weight
___ Can't lose weight
___ Can't get started without coffee
___ Chemical or pesticide exposure
___ Chronic fatigue or depression
___ Cry easily without a cause
___ Depressed for long periods
___ Earaches
___ Eat often or else feel faint/nervous
___ Eyes often red, inflamed
___ Face and/or eyes get puffy
___ Facial twitches
___ Gum problems
___ Headaches
___ Headaches in the morning, wears off
___ Heart palpitations when hungry
___ Heart palpitations after eating
___ Highly emotional
___ Highly controlled
___ Impaired hearing
___ Recent increase in weight
___ Lack of sensation somewhere in the body
___ Likes depressants
___ Likes stimulants
___ Lower back pain
___ Frequent muscle cramps
___ Nails split and brittle
___ Nosebleeds frequently
___ Electronic equipment and computer in work or home environment
___ Ringing in ears
___ Pulse speeds up after meals
___ Sensitive to cold weather
___ Sensitive to hot weather
___ Sensitive to high humidity
___ Sensitive to low humidity
___ Sexual desire decreased
___ Sexual desire increased
___ Stuffy nose during the day
___ Stuffy oose in the evening/night
___ Tendency towards anemia
___ Tremors in hands or neck
___ Varicose veins
___ Weight gain in upper arms/shoulders/back of neck

Additional things you wish to mention:

_____

_____

_____

_____

_____

Sundardas
Naturopathic Clinic
Your Natural Partner in Wellness

NAME: ______________________________

FOR OFFICIAL USE						
DATE	TREATMENT		PRESCRIPTION		NEXT APPT	DIAGNOSIS
		COST	ITEM	DOSAGE		

Sundardas Naturopathic Clinic

Your Natural Partner in Wellness

NAME: ______________________________

DATE	NOTES

Sundardas
Naturopathic Clinic
Your Natural Partner in Wellness

NAME: ______________________________

CHRONOLOGY OF LIFE EVENTS

AGE	EVENT