



HealthQuest - Confidential Questionnaire - Female

In order for us to provide you with quality health care, please provide us with the following information regarding your present state of health and medical history. Please note that all of this information is required by us to make an accurate assessment of your individual needs and to help you achieve the best possible results and is **completely confidential**.

Name		Date
Address		
Home Ph	Work	Mobile
Email address		
Date of Birth	Age	Blood type
Have you previously received Acupuncture / Chinese Medicine / Alternative / Complimentary / Naturopathic Care?		
How did you hear about our clinic? <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Yellow pages <input type="checkbox"/> Dr Referral <input type="checkbox"/> Internet <input type="checkbox"/> Other		

What are the main reasons that you have sought help for: (Select as many as you wish)

- Treatment of a Specific Health Concern as described in the Main Complaints section below**
- Weight Loss Disease Prevention Pre-conception care Cardiovascular protection
 Diet Low Energy Immune system Sports performance

Goals and Expectations

What do you hope to get from today's consultation? _____

Rate the following questions from 1 to 10 ... **1 = very poor** and **10 = excellent**

1. How do you rate your present level of health?
2. How do you rate your present level of energy or vitality?
3. How committed are you to improving your health?
4. How confident are you in making suggested dietary, lifestyle and exercise modifications to improve your health and wellbeing?

Are you willing to make changes to your diet and lifestyle to improve your health?

- Yes No Maybe

Are you willing to increase your aerobic capacity with an exercise program?

- Yes No Maybe

Are you willing to increase your strength and stamina with a strength resistance training program?

- Yes No Maybe

How long do you feel it would take you to achieve your health and lifestyle goals?

- Days Weeks Months Years

What do you think could stop you from achieving your health goals?

- Time Interest Support Money Commitment Health Other



HealthQuest - FEMALE Symptom Analysis

First Name: _____ Last Name: _____ Date: _____

Scoring Circle the score in the column that best suits your symptoms, in either Severity or Frequency.

Severity Frequency
 Column **A** = Never
 Column **B** = Mild ——— or - Infrequent Symptoms (twice per week or less)
 Column **C** = Moderate — or - Frequent Symptoms (3 to 6 times a weekly)
 Column **D** = Severe ——— or - Daily Symptoms

Note: Circle the zeros if there is no symptom as well as numbers when there is a symptom

Section 1.	A	B	C	D
1. Curved spine, height loss, stooped base of neck hump (dowager's hump)	0	2	5	10
2. Bone pain, back, hip or knee pain	0	2	5	10
3. Spinal problems, pain, Sciatic pain	0	2	5	10
4. Osteoporosis	0	2	5	10
5. Recent broken bones, fractures	0	2	5	10
6. Arthritis - Osteo/Rheumatoid	0	2	5	10
7. Joints swelling painful, deformity, injury, stiffness	0	2	5	10
8. Noisy joints (creak, grind etc.)	0	1	3	5
9. Nodules on fingers	0	2	5	10
10. High uric acid level	0	2	5	10
11. Damaged disc, slipped disc	0	2	5	10
12. Bursitis or tendonitis	0	1	3	5
1. Total				
Section 2.				
1. Tightness or pain in back, neck or shoulder muscles	0	2	5	10
2. Muscular spasms, cramping	0	2	5	10
4. Stiffness in muscles	0	2	5	10
5. Tenderness, pain in muscles	0	2	5	10
6. Weakness in muscles	0	2	5	10
7. Trembling (fasciculation)	0	2	5	10
2. Total				
Section 3.				
2. Chest tightness on stress or exertion	0	2	5	10
3. Palpitations, arrhythmias, extra beats	0	2	5	10
4. Swelling of the ankles	0	2	5	7
5. Shortness of breath on exertion/rest	0	1	3	5
6. Calf pain on exercise	0	2	5	7
7. Dizziness on exertion	0	2	5	7
8. Previous angina attacks, heart attack or stroke	No	Yes	(10)	

Section 3 continued ...	A	B	C	D
9. Known cardiac murmur or condition	No	Yes	(10)	
10. High blood cholesterol, triglycerides or blood clotting problems	No	Yes	(10)	
11. Blood Pressure or Heart medication	No	Yes	(15)	
3. Total				
Section 4.				
1. Blue, numb, cold fingers or toes	No	Yes	(10)	
2. Ulcers, sores on legs and feet	No	Yes	(10)	
3. Shiny, discoloured, hairless skin on arms or legs / Varicose veins	No	Yes	(10)	
4. Cramps, pain in legs when walking	0	2	5	10
6. Pins and needles, numbness - hands, feet	0	1	3	5
7. Fluid retention feet, legs, body	0	2	5	10
8. Difficulty with written or spoken words or concentration	0	1	3	5
9. Dizziness, ringing in the ears	0	1	3	5
10. Fleeting nausea / Hearing loss	0	1	3	5
11. Previous deep vein thrombosis	0	2	5	10
12. Take Anti-clotting medication	No	Yes	(18)	
4. Total				
Section 5.				
1. Morning headaches	0	1	2	3
2. Feel tired, nervy, weak	0	1	2	3
3. Ringing in ears / Sleepy, dizzy	0	1	2	3
4. Hi Blood Pressure / Heart medication	No	Yes	(15)	
5. Flushing with no known cause	0	1	2	3
6. Tingling and numb hands and feet	0	1	2	3
7. Blurry vision	0	1	2	3
5. Total				

Section 21.	A	B	C	D
1. Breast lumps	0	2	5	10
2. Breast tenderness	0	1	3	5
3. Ovarian cysts, Fibroids	No	Yes	(10)	
4. Endometriosis	No	Yes	(10)	
5. Family history of cysts / cancer	No	Yes	(10)	
6. Abnormal pap smears	No	Yes	(10)	
7. Cervical erosions	No	Yes	(10)	
8. Mid-cycle pain	0	1	3	5
9. Hormonal birth control	No	Yes	(10)	

21. Total

Section 22.	A	B	C	D
1. Insomnia	0	1	3	5
2. Joint pain	0	1	3	5
3. Fatigue	0	1	3	5
4. Low libido	0	1	3	5
5. Mood changes	0	1	3	5
6. Menstrual irregularity	0	2	5	7
7. Hair loss	0	2	5	7
8. Menorrhagia (heavy periods)	0	2	5	7
9. Dry vagina	0	2	5	7
10. Night sweats, Hot flushing	0	2	5	10

22. Total

Section 24.	A	B	C	D
1. Light headedness/vertigo	0	2	5	7
2. Walking difficulties	0	2	5	7
3. Poor bowel / bladder control	0	2	5	7
4. Speech difficulties	0	2	5	7
5. Weakness of limbs	0	2	5	7
6. Paralysis, spasticity	No	Yes	(10)	
7. Poor co-ordination / balance	0	2	5	7
8. Muscle twitching	0	2	5	7
9. Sensory, perception changes - temperature, numbness, tingling	0	2	5	10
10. Short / long-term memory loss	0	2	5	10

24. Total

Section 25.	A	B	C	D
1. Cerebravascular - Stroke, transient ischaemic attacks, haemorrhage	No	Yes	(15)	
2. Alzheimer's disease senile dementia	No	Yes	(15)	
3. Tremor	0	2	5	10
4. Parkinson's disease	No	Yes	(15)	
5. Motor neurone disease	No	Yes	(15)	
6. Epilepsy	No	Yes	(15)	

25. Total

Section 26.	A	B	C	D
1. Chronic pain at any site	0	2	5	10
2. Headaches, migraines, cluster headaches	0	2	5	10
3. Neuralgia - Trigeminal following herpes/shingles infection	0	2	5	10
4. Addiction to recreational drugs	No	Yes	(15)	
5. Difficulty giving up smoking	No	Yes	(15)	
6. Need to have at least one alcoholic drink each day	No	Yes	(15)	
7. Reflex sympathetic dystrophy	No	Yes	(15)	
8. Chronic arthritis	0	2	5	10
9. Food addiction/ anorexia/ bulimia	No	Yes	(15)	
10. Depends on medication for pain	No	Yes	(15)	

26. Total

Section 27.	A	B	C	D
1. Forgetful	0	2	5	10
2. Difficult concentration	0	2	5	10
3. Treated for schizophrenia	No	Yes	(15)	
4. Depression	No	Yes	(15)	
5. Obsessive compulsive disorder	No	Yes	(15)	
6. Easily distracted, learning problems	0	2	5	10
7. Suicidal thoughts	No	Yes	(15)	
8. Anxiety, Waking with anxiety	No	Yes	(15)	
9. Panic Attacks	No	Yes	(15)	
10. Mood swings	0	2	5	10

27. Total

Section 28.	A	B	C	D
1. Vivid dreams	0	1	3	5
2. Light sleep	0	1	3	5
3. Sleep talking	0	1	3	5
4. Sleep walking	0	1	3	5
5. Snoring (sleep apnoea)	0	1	3	5
6. Difficulty falling asleep	0	1	3	5
7. Early morning waking	0	1	3	5
8. Frequent waking	0	1	3	5
9. Wake during night with difficulty getting back to sleep	No	Yes	(5)	
10. Waking up exhausted	0	1	3	5

28. Total