



Nicky Gonis Holistic Health

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____

Height: _____ Weight: _____

Name of GP: _____ Suburb: _____

Name of Specialist: _____ Suburb: _____

Specific reason for your appointment and other current health concerns:

1. _____

2. _____

3. _____

Recent pathology/tests/investigations/operations and dates performed.

Have you experienced major stress in the last 12 months? (for example, death in the family, divorce, bankruptcy) Please describe



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Naturopath | Herbalist | Gut Health

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General Health Questionnaire:

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

<p><u>Gastro-intestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bloating <input type="checkbox"/> Flatulence <input type="checkbox"/> Reflux/Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Food intolerances <input type="checkbox"/> IBS <input type="checkbox"/> Chrono's disease <input type="checkbox"/> Ulcerative colitis 	<p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Persistent cough <input type="checkbox"/> Sneezing, wheezing <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Ear infections <input type="checkbox"/> Itchy eyes, ears, nose, throat <input type="checkbox"/> Sore throat <input type="checkbox"/> Asthma <input type="checkbox"/> Excessive mucous 	<p><u>Skin</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Slow wound healing <input type="checkbox"/> Acne <input type="checkbox"/> Psoriasis <input type="checkbox"/> Dry, flaky skin <input type="checkbox"/> Oily skin <input type="checkbox"/> Eczema / skin rashes <input type="checkbox"/> Rosacea <input type="checkbox"/> Vitiligo <input type="checkbox"/> Hives <input type="checkbox"/> Cold sores 	<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/> Palpitations <input type="checkbox"/> Dizziness <input type="checkbox"/> Varicose veins <input type="checkbox"/> Low blood pressure <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Arrhythmia
<p><u>Immune/Lymphatic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor immunity <input type="checkbox"/> Recurrent cold / flu <input type="checkbox"/> Hay fever / sinusitis <input type="checkbox"/> Fluid retention <input type="checkbox"/> Cold sores <input type="checkbox"/> Inflamed / bleeding gums <input type="checkbox"/> Auto-immune disease <input type="checkbox"/> Cancer <input type="checkbox"/> HIV 	<p><u>Sleep</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Insomnia <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Waking during night <input type="checkbox"/> Waking un-refreshed <input type="checkbox"/> Nightmares <input type="checkbox"/> Night sweats <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apnea 	<p><u>Emotional</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> Poor memory <input type="checkbox"/> High stress levels <input type="checkbox"/> Feelings of being overwhelmed or unable to cope <input type="checkbox"/> Apathy 	<p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Muscle aches or cramps <input type="checkbox"/> Joint pain <input type="checkbox"/> Restless legs <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle twitches <input type="checkbox"/> Poor recovery/fatigue after exercise
<p><u>Endocrine</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue / poor energy <input type="checkbox"/> Recent weight gain <input type="checkbox"/> Heat / cold intolerance <input type="checkbox"/> Hair falling out <input type="checkbox"/> Abdominal weight gain <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Hashimoto's disease <input type="checkbox"/> Grave's disease <input type="checkbox"/> Diabetes 	<p><u>Urinary / Renal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain with urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Bloody, cloudy or smelly urine <input type="checkbox"/> Urinary tract infection 	<p><u>Male hormone balance</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Low libido <input type="checkbox"/> Difficulty starting urine flow <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Difficulty maintaining erection <input type="checkbox"/> Genital rash or irritation <input type="checkbox"/> Painful testicles 	<p><u>Female hormone balance</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hot flushes <input type="checkbox"/> Night sweats <input type="checkbox"/> Change in menstrual cycle <input type="checkbox"/> Dry hair, skin or vagina <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Infertility <input type="checkbox"/> Miscarriage



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<u>Pre-menstrual symptoms (women only)</u>	<u>Menstrual symptoms (women only)</u>	<u>Sexual Health</u>	<u>Lifestyle</u>
<input type="checkbox"/> Depressed or teary	<input type="checkbox"/> Long intervals between cycles	<input type="checkbox"/> Thrush	<input type="checkbox"/> Smoker ____ / day
<input type="checkbox"/> Anxious or irritable	<input type="checkbox"/> Cycles longer than 32 days	<input type="checkbox"/> Genital herpes	<input type="checkbox"/> Passive smoker
<input type="checkbox"/> Feeling aggressive or angry	<input type="checkbox"/> Cycles shorter than 24 days	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Coffee ____ / day
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Heavy blood flow or flooding	<input type="checkbox"/> Irregular pap smear	<input type="checkbox"/> Tea ____ / day
<input type="checkbox"/> Food cravings	<input type="checkbox"/> Passing of blood clots	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Alcohol ____ / week
<input type="checkbox"/> Fluid retention/bloating	<input type="checkbox"/> Very light blood flow	<input type="checkbox"/> Burning or itching pain on genitals	<input type="checkbox"/> Recreational drugs
<input type="checkbox"/> Back pain	<input type="checkbox"/> Spotting before or after bleed	<input type="checkbox"/> HPV	<input type="checkbox"/> Exercise ____ / week
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Excessive plane travel
<input type="checkbox"/> Headaches or migraines			<input type="checkbox"/> Radiation exposure
<input type="checkbox"/> PMDD			<input type="checkbox"/> Pesticide / herbicide exposure
<input type="checkbox"/> Cravings			<input type="checkbox"/> Bleach and ammonia use (cleaning)
			<input type="checkbox"/> High stress levels



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Please list any health concerns of family members including siblings, parents and grandparents:

Current medications (including dosage):

Current supplements (dose and brand):

List any other health concerns you have: _

What are your main 3 treatment goals or expectations?

1. _____

2. _____

3. _____

Do you follow a specific diet? i.e Vegan, Vegetarian, Gluten Free, Dairy Free, Paleo, Keto?

Yes

No

Which diet? _____

If you answered yes, are you willing to change your diet for health benefits?

Yes

No

If No, please explain why _____

Please understand that all information is held in strict confidentiality. It is very important that the client builds a strong sense of trust with the practitioner. If there is anything further you would like to discuss with me before the session or any boundaries that you would like to set to ensure your comfort and relaxation, please bring these issues to my attention.

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INTAKE FORM



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