Nicky Gonis Holistic Health
Naturopath | Herbalist | Gut Health

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

_____

_____

_____

Nicky Gonis Holistic Health
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General Health Questionnaire:
Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if you have never experienced this symptom.

Gastro-intestinal	Respiratory	Skin	Cardiovascular
☐ Bloating	☐ Persistent cough	☐ Slow wound healing	☐ Excessive fatigue
☐ Flatulence	☐ Sneezing, wheezing	☐ Acne	☐ Shortness of breath
☐ Reflux/Heartburn	☐ Post nasal drip	☐ Psoriasis	☐ Easy bruising or bleeding
☐ Indigestion	☐ Ear infections	☐ Dry, flaky skin	☐ Palpitations
☐ Nausea	☐ Itchy eyes, ears, nose, throat	☐ Oily skin	☐ Dizziness
☐ Abdominal pain	☐ Sore throat	☐ Eczema / skin rashes	☐ Varicose veins
☐ Constipation	☐ Asthma	☐ Rosacea	☐ Low blood pressure
☐ Diarrhea	☐ Excessive mucous	☐ Vitiligo	☐ High blood pressure
☐ Food intolerances		☐ Hives	☐ High cholesterol
☐ IBS		☐ Cold sores	☐ Arrhythmia
☐ Chrone's disease			
☐ Ulcerative colitis			

Immune/Lymphatic	Sleep	Emotional	Musculoskeletal
☐ Poor immunity	☐ Insomnia	☐ Depression	☐ Headaches
☐ Recurrent cold / flu	☐ Difficulty falling asleep	☐ Anxiety	☐ Migraines
☐ Hay fever / sinusitis	☐ Waking during night	☐ Mood swings	☐ Muscle aches or cramps
☐ Fluid retention	☐ Waking un-refreshed	☐ Poor memory	☐ Joint pain
☐ Cold sores	☐ Nightmares	☐ High stress levels	☐ Restless legs
☐ Inflamed / bleeding gums	☐ Night sweats	☐ Feelings of being overwhelmed or unable to cope	☐ Muscle weakness
☐ Auto-immune disease	☐ Snoring	☐ Apathy	☐ Muscle twitches
☐ Cancer	☐ Sleep Apnea		☐ Poor recovery/fatigue after exercise
☐ HIV			

Endocrine	Urinary / Renal	Male hormone balance	Female hormone balance
☐ Fatigue / poor energy	☐ Excessive urination	☐ Low libido	☐ Hot flushes
☐ Recent weight gain	☐ Frequent urination	☐ Difficulty starting urine flow	☐ Night sweats
☐ Heat / cold intolerance	☐ Pain with urination	☐ Premature ejaculation	☐ Change in menstrual cycle
☐ Hair falling out	☐ Incontinence	☐ Difficulty maintaining erection	☐ Dry hair, skin or vagina
☐ Abdominal weight gain	☐ Bloody, cloudy or smelly urine	☐ Genital rash or irritation	☐ Low libido
☐ Thyroid disorder	☐ Urinary tract infection_	☐ Painful testicles	☐ Excessive libido
☐ Hashimoto's disease			☐ Bleeding after intercourse
☐ Grave's disease			☐ Infertility
☐ Diabetes			☐ Miscarriage

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