Confidential Health Inventory and Indemnity

Dr. Tiva Luckett
Registered Naturopath AHPCSA, MSANA
BHSc.Nat.(AUS), Dip.Herb.Med., Dip.Nutr.
info@naturopathy.co.za . www.naturopathy.co.za . Cell 0761584242

GENERAL INFORMATION Date _____

Date of Birth _____ Place of Birth _____

Surname _____ First name _____

Address _____

Post Code_____ P.O. Box _____

Phone Work _____ Home _____

Cell _____ Email _____

Occupation: _____

	Full time	Part time	Retired	Student	Unemployed	Other
Status	Single	Partner	Married	Divorced	Widowed	

How did you hear about us? _____

Emergency Contact

Name _____ Relationship _____

Phone number _____ Cell number _____

Current healthcare provider/s names and phone numbers _____

_____

Current medication (prescription, over the counter, vitamins, herbs, and dosage) _____

_____

_____

Past medications (prescription only) _____

_____

Allergies *Please also state what happens if you come into contact with these allergens*

Drug allergies (penicillin etc.) _____

Food allergies: (gluten, shell fish, etc) _____

Environmental allergies (feathers, pollen, etc) _____

Other/notes _____

Purpose of this consultation: _____

_____

_____

_____

Any present illness / conditions / diseases (if different from above) _____

_____

_____

Hospital admissions / operations (include dates) _____

_____

Past medical conditions

high/low blood pressure	heart trouble	diabetes	kidney trouble
liver disease	epilepsy	asthma	arthritis
chronic fatigue	cancer	eating disorder	anaemia
ulcer	diverticulitis	mental illness	addiction

Details: _____

_____

Other past illness / disease / diagnosis _____

_____

Living situation Alone Friends Partner Spouse Parents Family

Pets and how many _____

Number of children Girls 1 2 3 4 Boys 1 2 3 4

Ages of children living with you: _____

Habits

What routine exercise do you do _____

For how long _____ How often _____

How many cups a **day** of: *Please be specific, e.g. 2 espressos + 2 sugars, beer or gin etc*

Coffee _____ Ceylon Tea _____

Soft/diet drinks _____ Herbal/rooibos tea _____

Cordial juice _____ 100% fruit juice/fresh juice _____

Alcohol (how much a day, what kind) _____

How many cigarettes a day? _____ How many years? _____

Previous smoking? How many a day? _____ For how many years?_____

Mood altering substances past and present _____

Blood Group_____

Family History

Member of family	Serious disease / illness / addiction past or present	Living	Cause of death and age
Mother			
Father			
Sister/s			
Brother/s			
Mother's mother			
Mother's father			
Father's mother			
Father's father			

Digestive system

Please give an example of what you eat in a day

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Symptoms

Bloating	Flatulence	Indigestion	Cramps/pain
Nausea	Coeliac disease	Vomiting	Constipation
Diarrhoea	Haemorrhoids	Blood in stool	Pus in stool
Reflux	Irritable bowel	Crohns disease	Ulcerative colitis
Diverticulitis	Peptic ulcer	Hiatus hernia	Bad breath

Details _____

Intolerance to fat and/or alcohol, any other intolerances _____

Other symptoms _____

_____

How often fo you have a bowel movement _____

Please describe (loose, chageable, colour, consistency etc) _____

Any other symptoms on passing a stool (blood, painful etc) _____

Any other notes on digestion, food, diet etc _____

_____

_____

_____

Female Reproductive System

Age period started _____ Date of last pap smear _____

Were the results abnormal _____ What were the results if abnormal _____

Treatment _____

Current birth control method _____ Date started _____

Previous birth control _____ How long _____

Number of days between periods/length of cycle _____

Number of days of flow _____ Heavy/medium/light _____

How many times do you change pad/tampon/mooncup _____

Symptoms

What symptoms do you experience during menstruation _____

_____

What premenstrual symptoms do you experience _____

_____

Any other symptoms, and at what stage of your cycle _____

_____

Pregnancies

Are you pregnant *(which trimester)* or breast-feeding _____

Full term, how many? _____

Pregnancy complications _____

Birth experiences and complications _____

Abortions/Miscarriages How many? _____When? _____

Any history of STD or STI? _____

Do you experience any of the following

Vaginal discharge? Please describe _____

Vaginal odour? Please describe _____

Vaginal itch? Please describe _____

Pain during sex? Please describe _____

Libido levels out of 5 (0 = non-existant and 5 = high) _____

Infertility issues _____

IVF, when, how many times? _____

Do you know when you are ovulating, if so when _____

Other symptoms or concerns _____

_____

_____

Male Reproductive System

Erectile dysfunction _____

Premature ejaculation _____

Jock itch _____

Discharge/pus _____

STD/STI _____

Prostate problems _____

Libido levels out of 5 (0 = non-existant and 5 = high) _____

Infertility issues _____

Has your partner had IVF, when, how many times? _____

Other symptoms_____

_____

_____

Circulatory system

Do you get	Cold hands	Cold feet	Dizziness	Pins and needles
Do you have	Angina	Heart murmur	Palpitations	Chest pain

High or low blood pressure _____

Please describe any of the above symptoms _____

Other symptoms _____

_____

_____

Respiratory System

Asthma	Wheezing	Short of breath	Coughing blood	Bronchitis
Pneumonia	Whooping cough	Mucous	Sinusitus	Sore throat

Please describe any of the above symptoms _____

Other symptoms _____

_____

_____

Urinary System

Cystitis	Kidney infection	Urinate often	Blood in urine	Pus in urine
Incontinent	Painful urination	Urinate at night	Urgency	Strong odour

Please describe any of the above symptoms _____

Other symptoms _____

_____

_____

Nervous System

Stress	Anxiety	Panic attacks	Depression	Anger
Sadness	Nervous	Worry	Suicidal	Lonely
Palpitations	Spaciness	Poor memory	Irritable	Poor concentration

Please describe any of the above symptoms _____

Other symptoms _____

_____

_____

Have you fainted in the past_____

Sleep

Number of hours sleep _____ From _____am/pm Until _____am/pm

Insomnia	Wake tired	Sleep lightly	Sleep heavily	Snore
Dream	Nightmares	Wake often	Work night shifts	

Please describe any of the above symptoms _____

Other symptoms_____

_____

_____

Skin

Eczema	Psoriasis	Acne	Rash	Flushes
Itchy	Dry	Easy bruising	Sweating excessively	

Please describe any of the above symptoms _____

Other symptoms_____

_____

_____

Muscles & Joints

Pain	Swelling	Stiffness	Weakness	Cramp
Injury	Damage	Injury		

Arthritis, what kind and where, please describe symptoms and when they are worse or better _____

Other symptoms _____

Physical

Height _____ Weight _____Kg

Describe your complexion _____

Nails *(any white spots, horizontal or vertical lines, weak, strong, cracking, discolouration)*_____

Describe your tongue if you look in a mirror *(any lines, teeth marks, coating, shaking, colour of tongue)* _____

Blood Pressure _____

Glucose _____ Cholesterol _____

Any other/extra notes you would like to add, or if there is more information you would like to give:

Thank you for taking the time to complete this form.

Consent to Treatment & Fees Policy

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, including physical, mental, emotional and spiritual aspects of the individual.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or are breast-feeding, please let us know. Please inform us of all allergens. There may be slight health risks to treatment by naturopathic medicine. These include, but are not limited to: aggravation of pre-existing symptoms or allergic reactions to herbs or supplements. Results to treatment are not guaranteed and not all risks and complications can be anticipated or explained. Please stop the prescribed medication, or contact us, immediately if you experience any unusual or unpleasant side effects from the herbs or supplements.

Payment is made by credit card or EFT with submission of this form:

On line initial consultation R300

Payable to:

Tiva Luckett
Standard Bank
Account number 071315802
Branch number 024909
Branch Mowbray

• Supplements and products are individually priced and paid for and can be claimed for from some medical aids, as can the consultation fee, please retain your receipt for this purpose.

Consent Regarding Personal Information:

Your identity will be protected at all times and a record kept of the health services provided. If the information from medical records is analysed for research purposes then identity will be protected and kept confidential.

How our clinic collects, uses and discloses patients' information:
• To assess your health concerns, to provide health care and advise you of treatment options.
• To establish & maintain contact with you and remind you of upcoming appointments.
• To communicate with your other health-care providers if necessary.
• To complete claims for health insurance purposes.
• To comply with legal and regulatory requirements of our regulatory body AHPCSA (Naturopathy).
• To invoice for goods and services or collect unpaid accounts.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent:

I, _____*(patient name)* consent to diagnostic and therapeutic procedures for the treatment for my present condition(s), and understand that I am free to withdraw consent and to discontinue participation in these procedures at any time. I have read, fully understand and agree to the outlined fees and policies, and understand that the fees may change without prior notice.

Signature: _____ Date: _____