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? ☐Friend ☐Family ☐Yellow pages ☐Dr Referral ☐Internet ☐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, arrythmias, 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. Dizzyness, 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 ....

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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.				
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.				
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. M otor neurone disease	**No**		**Yes**	(15)
6. Epilepsy	**No**		**Yes**	(15)

25. Total ....

Section 26.				
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.				
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.				
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 ....

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