WINDMILL HILL MEDICAL

Wellness Health Questionnaire

Please take the time to fill out this questionnaire. Your response will help provide a valuable insight into the key areas and patterns in your life. Your answers will be held confidentially. Dr. Alison Timms MBBS, FRACGP, Dip Dermatology, Integrated Practitioner, Smart DNA Practitioner, Member ACNEM, ACNIM

CONTACT INFORMATION

Full name .....

Residential address ..... Postcode .....

Email .....

Phone - Home ..... Work ..... Mobile .....

Date of birth ..... Age ..... Gender .....

Relationship status (single/married/live with partner or separately/same sex) .....

Do you have Children? (ages/sex/any problems) .....

Occupation .....

Studies (are you studying anything at present/part of a course or self study? List any courses/ degrees/diplomas/certificates) .....

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WELLBEING HISTORY

What is your main problem about your wellbeing at present? .....

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How long have these problems or concerns been affecting you?

And to what extent do they affect your work sleep/exercise/meals/relationships? .....

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Have you been prescribed any medications for your concerns or problem?

If so, please list. Are you taking them? .....

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What other therapies have you tried? e.g. acupuncture/osteopath/neuropathology etc.

Please describe any positive or negative responses. .....

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Have you had any tests? e.g. bloods/scans. Please list any known results.

Are you worried/concerned about any of the results?

List any concerns about testing that has or hasn't happened?

List any past medical problems. Please include any problems that have involved chemotherapy, radiation, long courses of antibiotics and/or steroids.

CHILDHOOD

Please give any known details of your birth history. e.g. were you a premature baby, delivered by caesarean/any know physical/ emotional trauma. Do you know if your mum or dad had a drug problem while you were in utero?

Have you had any significant childhood emotional or physical trauma? If so, give some details.

Briefly describe your childhood. Did you feel wanted, loved,cared for? Or was it a survival experience?

During your childhood did you develop 'normally'. e.g. did you have co ordination problems,

did you start puberty early or late, did you have any speech/hearing/vision problems? .....

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SCHOOL & INTERESTS

What type of schooling did you experience? e.g. religious/private/same sex/state schools etc. .....

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Briefly describe your schooling experience. What were your strengths and weaknesses at school?

e.g. English was easier than maths. Did you make friends easily? Did you experience bullying ? Did you get along with teachers/authority figures?

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Did you have any interests outside of school such as sports, dancing, theatre, equestrian events? .....

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Did you reach a high level of achievement? .....

Are you still participating in some of these activities now? .....

Do you think you are a competitive person? .....

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FAMILY

Did you have a supportive family? Or have you had to separate and find outside support?

If so, do you feel you have good people in your life? .....

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Do you know of any medical problems running in the family?

e.g. Cancers, diabetes, heart problems, joint problems, emotional problems, addiction problems etc. Please list the problem. .....

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Please list any surgery that you have had. .....

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DAILY HABITS

Please list any allergies that you have. This can be to medications, food, insects, dust, pollens etc. .....

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Do you feel that you are sensitive to chemicals? e.g. perfumes give you a headache, taking one panadol will sedate you, or drinking coffee will keep you awake. .....

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Do you smoke? .....

If so, how much, and what do you smoke? What triggers you to smoke? Do you now why you smoke?

e.g. to relieve stress levels, control weight etc. .....

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Do you drink alcohol? If so, list what you drink and how much. e.g. wine or beer, most nights, only weekends, tend to binge. etc

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Do you use speed, ecstasy, cannabis, heroin, any illicit drugs? If so, how much and how often? .....

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Do you drink energy drinks such as red bulls? if so, how much, which type and how often?

Do you drink soft drinks? If so how much? .....

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Do you drink tea or coffee? if so, how much? .....

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Do you drink water? How much per day? .....

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Wellness Health Questionnaire

List what you would eat for breakfast on a typical day? .....

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List what you would eat mid morning? .....

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List what you would eat for lunch on a typical day? .....

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List what you would eat in the afternoon? .....

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List what you would eat for dinner on a typical day? .....

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How often do you eat out? How often do you buy take away food? List what type of food you would have?

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Have you ever fasted? If so, for how long? .....

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Have you been on any specific diets? e.g. raw food, paleo, Atkins etc.

If so, for how long and what was the reason? .....

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What is your height? .....

What is your weight? .....

Do you exercise? If so, what do you do and how often? .....

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Do you enjoy exercise? .....

Do you play any sports? Please list. .....

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WELLNESS & SPIRITUALITY

What is your sleep pattern like? .....

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Do you have any problems with sleep? e.g. you find it hard to get to sleep, or you wake early. .....

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Do you snore? Do you have sleep apnoea and need to use an aide such as cpap? .....

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How do you relax? .....

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Do you practice meditation? If so, for how long and how often? .....

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Please comment on your expectations about your health and well being.

Do you have any goals? If so, please list. .....

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Do you find it hard to make changes? Is it hard for you to stick to new ways of living? .....

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What motivates you? .....

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How do you think you learn? e.g. are you more a visual, or tactile person?

What things do you understand easily? .....

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Do you take time out to reflect on your life, relationships etc? .....

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Do you practice any religion? .....

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Would you describe yourself as a spiritual person or atheist? .....

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Is your family or significant friends identified as a particular religion? .....

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MEDICAL ISSUES

Please list any joint, bone or muscle problems. .....

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List any problems you have with your eyes. .....

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Do you need glasses? .....

List any problems regarding your hearing. .....

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List any problems regarding your nose and throat. e.g. recurrent sore throat, blocked nose. Please include any issues. .....

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List any problems regarding your stomach, bowel, liver, spleen, gall bladder, pancreas. .....

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What is your usual pattern in relation to passing stools? e.g. constipation, diarrhoea, blood in stool, mucous in stool. .....

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List any problems you have regarding your bladder and kidneys. e.g. frequent urinary infections, kidney stones. .....

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Wellness Health Questionnaire

List any problems have you had any or suffer from ongoing sexually transmitted diseases? Please list. .....

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Please describe your menstrual cycle. e.g. regular, painful, heavy flow, flooding, age of when period started. .....

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Have you been pregnant? .....

Do you have children? .....

When was your last Pap smear? .....

Have the Pap smears been normal? .....

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List any problems you have with your lungs? .....

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List any problems you have with your skin. e.g. acne, dermatitis, loss of hair etc. .....

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List any problems regarding your heart. e.g. any issues with blood pressure, irregular heart beats, chest pains etc. .....

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List any problems regarding your emotional well being. e.g. episodes of depression, anxiety, self harm, suicide attempts etc.

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Do you suffer with headaches, migraines, epilepsy? If so, please describe. .....

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Wellness Health Questionnaire

Do you have any problems with your temper? Are you easily irritated, confused, have memory problems, poor coordination, loss of balance? .....

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Have you experienced any head injuries? Have you been in any significant car/work accidents?

Please list any long term problems. .....

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Is there anything else that you feel is important for me to know? .....

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I have read and understood the Privacy Policy provided by this practice and I consent to the collection and use of my information as described in the Privacy Policy. I also agree to participate in this practice's recall and reminder systems.

Signature of patient/person responsible* ..... **Date** ..... **/** ..... **/** .....

Print full name .....

*A 'person responsible' means a person defined as a 'person responsible' under the Privacy Act 1998 including the patient's partner, family member, carer, guardian, close friend, and a person exercising power