Female Client First Time Evaluation Form

Angela Frieswyk, Medical Herbalist & Holistic Nutritionist, Tauranga

Please Note the following:

1. Prior to your very first consultation, could you please fill-in the attached form and send it to me by email to angela@herbalist.kiwi.nz or by post to 2 Westwood Street, Bellevue, Tauranga 3110. If sending your form by regular post, please ensure you post this to me at least 4 working days in advance of your appointment.
2. You only need to send me the "Questionnaire" part of the form, not this page nor the "Addendum to Questions" section below.
3. Allow a good 10-15 minutes to complete the form.
4. Some questions on this form are marked as "required" by showing an Asterix to the right of the question heading. Please answer these questions if you can.
5. **All information entered by you is kept strictly confidential**. The detail is used to allow me time to review your health basics and focus on priorities during your consultation.
6. If you have any recent/relevant blood tests or medical reports, please bring these with you (request a copy from your doctor's clinic or specialist).

Addendum to Questions

This Addendum to Questions simply list multi choice answer options to some questions, saving space on the form you will send me. The number references below relate the question number on the Questionnaire Form.

1. Referred by Question: Options: Friend or family, My Doctor, Other medical professional, Your Website, Your Facebook page, other (please state).
2. Sleep Question: Options: Restful, Restless / Wake up often, Hard to get to sleep, Bad dreams.
3. Menstruation question: None, Not Applicable, Cramping, Bloating, Feeling weak, Mood swings, Cravings, Heavy bleeding, Back Pain, Headaches, Bright red blood, Dark clotted blood, Other.
4. Question on type of spread used: Butter (Salted), Butter (Un-Salted), Butter Soft Spread, Margarine, Ghee, Olive Oil Spread, I do not use any type of spread, Other Spreads.
5. Question on Diet preferences/habits. Select multiple preferences that best describe your eating habits: I eat mostly homemade meals, I mostly eat out, I enjoy cooking, I prefer to get prepped meals, I eat mostly whole foods, I eat a lot of convenience food, I skip meals often, Vegetarian, Vegan, Mostly organic, follow a specific eating plan, e.g. Keto, intermittent fasting.

Questionnaire Form

Your Personal Details *:

Your Name: _____

Age in years: _____ Date of Birth: ____/____/_____

Address: _____

_____ Postal Code: _____

Mobile Phone Number: _____ Land Line Phone Number: _____

Email Address: _____

Your Doctors Name: _____ GP Practice: _____

Referred by (see Q1 of Addendum) _____

Your Health *:

Please list current complaints/symptoms and rate severity (1 to 10 scale, 10 being the most severe):

Please tell me any additional information about your health:

Your Medications/Supplements

Enter details on all your Medications, including birth control pills, pain medications, laxatives, etc. When listing your medications, please include details for each medication including Medication name, Dose, how long you have used it, why it was prescribed (if known).

What if any supplements you are taking?

Surgery History

Please list any surgery procedures you have had and the time period in years or months or weeks since you had this surgery.

Dental Work

If known, please provide details on the number of silver fillings, composite fillings, root canals or other dental work you currently have. Also note if you have current dental problems that need attending to.

Cigarette Smoking, Alcohol Consumption & Recreational Drugs

Cigarette Smoking:

Are you a current cigarette smoker? No / Yes

If so, how long have you smoked? _____

Current Smoker - How Many Cigarettes per day? _____

Ex Smoker? No / Yes

Ex Smoker - How long had you smoked? _____

Ex Smoker - How Many Cigarettes per day? _____

Alcohol Consumption:

How often do you drink alcohol?

When you do drink, what (wine, beer etc.) & how much do you consume?

Recreational Drugs:

Please only answer the following questions if you use any Recreational Drugs. Any information provided will be kept strictly confidential.

What Recreational Drugs do you use? Please provide information on how long you have used the drug and how much you regularly consume?

Sleep Questions and Stress Levels *:

How is your sleep? Select options that describe your sleep patterns. (see Q2 of Addendum). _____

Other Sleep Symptoms?

What time do you usually go to sleep? _____ What time do you usually awake? _____

Is your bedroom Dark or Light? Dark / Quite Light

Stress:

Please rate your current stress level (on a scale of 1 to 10, 10 being the highest) _____

What if any is the main reason(s) for your stress?

Family Illnesses:

Please provide details on any illnesses in the immediate family.

Father Illnesses:

Mother Illnesses:

Siblings Illnesses:

Your Children Illnesses:

Digestive, Bowel & Urination Health *:

Which of the following best describes your digestive health/symptoms? You can make multiple selections (circle answers):

Adequate / Poor / Acid reflux / Burp often / Burning / pain in stomach / Bloating / Other _____

Bowels Motions? Daily / More than once a day / I skip days

Stool Amount: Normal / Too little / Too Large

Stool Consistency: Normal / Too hard / Too soft

Stool Colour: Brown / Black / Yellowish / Other _____

Other Stool Issues. You can make multiple selections:

None / Lots of mucus / Lots of gas / Foul smell

Any other Stool related symptoms, including pain?

Urination problems?

Circle answers: None, Sense of urgency, too small amount, too large amount, Burning, Dribbling / incontinence, Unusual smell / Other _____

Do you need to get up out of bed & urinate several times over night? Yes / No

Menstruation, Menopause and related Questions:

Are you pregnant? No / Yes

Are you breastfeeding? No / Yes

Are your monthly periods regular (around 28 days cycles)? No / Yes

Symptom's experience associated with your period. (See Q3 of Addendum). You can make multiple selections.

Answers _____

Any other menstrual symptoms or changes?

Do you have children? Yes / No

How old are your children, if applicable? _____

Have your periods stopped? Yes / No

If applicable, have your periods changed or become irregular (please detail)? _____

Have you had a Hysterectomy? Yes / No

If you have had a Hysterectomy, when did you have it and why?

Please detail any other symptoms of menopause you are experiencing. _____

Exercise Questions / Working Life Questions

Do you exercise? Yes / Incidental exercise / No exercise

If so, what kinds of exercise do you participate in? _____

How often do you exercise?

When you exercise, how much time do you spend exercising? _____

Working question:

Do you work? Yes, full time / Yes, part time / Stay-At-Home Parent / Not currently working / Not working due to health condition or disability / I am Retired

Employment/Self-employment History. What kind of work do you (or did you) do? _____

Employment/Self-employment History. What kind of work do you (or did you) do?

If employed, how many hours do you work a week? _____

Dietary Questions *:

Please provide consumption details of a typical day's diet.

Breakfast: _____

Morning snack: _____

Lunch: _____

Afternoon snack: _____

Main meals: (Please circle option. Add the number of meals if applicable)

Red meat meals: I rarely or do not eat this option meals / ___ times a week / Every night a week.

Chicken meals: I rarely or do not eat this option meals / ___ times a week / Every night a week.

Fish meals: I rarely or do not eat this option meals / ___ times a week / Every night a week.

Egg meals: I rarely or do not eat this option meals / ___ times a week / Every night a week.

Vegetarian meals: I rarely or do not eat this option meals / ___ times a week / Every night a week.

Vegan Meals: I rarely or do not eat this option meals / ___ times a week / Every night a week.

Beverages:

Enter the number of drinks (cups) you consume per day.

Coffee _____, Tea _____, Green tea _____, Herb teas _____, Milk _____

Choice of milk types (if any): _____

Other Dietary Questions:

What type of Spread do you use (see Q4 in Addendum): _____

How many vegetables serves per day do you consume? (1 serve = ½ cup when raw)

Fruit - Choice and number of fruit per day?

Diet preferences/habits - (see Q5 in Addendum) List options that best describes your diet. You can list more than one as required. _____

If you follow a specific eating plan, e.g., Keto, intermittent fasting, please describe what specific eating plan do you follow? _____

Appointment Day Preferences to meet with Angela:

Please select your preferred appointment day and time of the day by ticking your preferences?

____ Any day that is available

____ Monday

____ Tuesday

____ Wednesday

____ Thursday

____ Friday

Time of Day for Appointment?

____ Any Time

____ A morning appointment

____ An afternoon appointment

Attach Medical Reports and Images?

Please attach any Recent/relevant blood tests or medical reports you may have that are relevant to your appointment with Angela.

Please list details of your attachments: