CONFIDENTIAL CLIENT INTAKE – WITH MENO RATING SCALE

This comprehensive intake form will take you between 15 to 25 minutes to complete. Please grab a cuppa.
Completing this will enhance our consultation process and let us to focus on what's really important for you.

TODAY'S DATE			
YOUR DETAILS			
Full Name		**Date of Birth**	
Phone (M)			
Email			
Postal Address for deliveries			
Occupation		**Hours work per week**	
Emergency contact			
Known Allergies or Intolerances			
Do you have medical implants/devices?			
Vaccination history (please include brand of covid vaccine)			

Please outline your SPECIFIC health aims – Why are you working with me?	
1.	
2.	
3.	
4.	

Do you have a current medical diagnosis?		
Have you had recent blood tests or other medical investigations?		***If so, can get a copy from your health practitioner for us to review before or during your consultation?***

Do you give permission for us to correspond with your GP/other health professionals if needed? (By discussing your case we can integrate your treatment plan)	**Yes**	**No**

Your GP's name		**Contact details**	
Other health practitioner		**Contact details**	

How do you rate your overall current state of health? (1= poor health, 10 = perfect health)	**/10**
How do you rate your current energy level, on a scale of 1 – 10? (1= low energy, 10 = bursting with energy)	

	/10
How do you rate your current stress levels on a scale of 1 – 10? (1= care free, 10 = stressed out)	**/10**

Current Weight (in kg)		**BMI** (if known, otherwise we'll calculate it)
Height (in cm)		

Which PHARMACEUTICAL medicines are you currently taking? Please include any contraception and MHT/HRT		
Name of product	**Dose / day**	**Duration of use/Reason for taking/Who prescribed?**

What NUTRITION, HERBAL or other supplements are you currently taking?		
Name of product	**Dose / day**	**Duration of use/Reason for taking/Who prescribed?**

Please indicate any areas of concern you've had in the PAST YEAR by ticking the box next to the sign or symptom. We can discuss in more depth during your consultation.					
MUSCULOSKELETAL:		**EYES:**		**NERVE:**	
Muscle pain		Poor vision		Dizzy/Giddy on rising	
Joint pain		Glaucoma		Fainting	
Arthritis		Macular degeneration		Tingling	
Broken bones		Other eye issues		Seizures	
SKIN:		**EARS:**		Memory loss	
Acne		Impaired healing		Headaches/Migraines	
Eczema/Psoriasis		Tinnitus/ ringing in ears		**RESPIRATORY:**	
Itching skin/Rash		Other ear issues		Short of breath	
Sore/Ulcers		**NOSE/SINUS:**		Cough	
Excessive dry skin		Infection		Wheeze/Asthma	
Hives/boils/large spots		Congestion/stuffy		Other lung issue	
MOUTH/THROAT:		Nose bleeds		**CARDIOVASCULAR:**	
Gum problems		Hay fever		Blood Pressure issues	
Sore throat		Itchy nose		Heart disease	
Other mouth/throat probs		**DIGESTIVE:**		Heart palpitations	
URINARY:		Problems swallowing		High Cholesterol	

Pain on urination		Stomach pain		Cold hands/feet	
Frequent infections		Nausea		Chest pain	
Inability to hold urine		Gall bladder stones/removed		History of heart disease in family	
Kidney stones		Heart burn		**MENSTRUAL CYCLE:**	
ENDOCRINE:		Diarrhoea		Irregular cycles	
Thyroid problems		Constipation		Menstrual cramping	
Hair loss		Change in appetite		PMS	
Sugar cravings		Bloating		Heavy bleeding	
Weight gain/loss		Flatus or burping		Breast tenderness	
MENOPAUSAL SYMPTOMS		**IMMUNE:**		Intermenstrual bleeding	
Hot flushes/sweats (Day)		Recurrent/frequent colds		Other issues	
Hot flushes/sweats (night)		Auto-immune		**MOOD:**	
Low libido		Sinus/ Ear/ Throat infections		Anxiety/ feeling impending doom	
Dryness (skin, eyes, vagina)		Urinary tract infections		Depression	
Brain fog		Cancer		Fluctuations	
Weight gain		Other		Other	
Other					

YOUR DIETARY INTAKE				
How would you describe your current diet?	Meat- eater	Vegetarian	Vegan	Other (what?)

Vegetables / DAY	**/cups Describe:**		
Fruit / DAY	**/pieces Describe:**		
Serves of red meat / WEEK			
Serves white meat / WEEK (Chicken, Pork)			
Serves of fish / WEEK			
Serves of sweets and desserts / WEEK (types)			
How many glasses of water do you drink / DAY?		**Is it filtered?**	
How many cups/ glasses do you have, on an average DAY, of the following:			
Caffeinated coffee:		**Sugar/milk**	
Caffeinated tea:		**Sugar/milk**	
Soft drinks:			
Decaffeinated coffee/Tea:		**Sugar/milk**	
Herbal Tea (what types?)		**Sweetener**	
Would you identify as addicted to any of the following? Alcohol, sugar, tobacco, caffeine, bread, fast food, other drugs, other (what?)			
Have you ever fasted before? If so, please provide details (what type of fasting, how long, how many times, how often?)			
Have you ever been on a detox? Please provide details.			

YOUR LIFESTYLE & HEALTH HISTORY	
Alcohol (numbers of standard drinks per week)	
Types of alcohol? (Eg beer, dark spirits, red wine)	
Number of alcohol free days (AFDs) per week?	
Are they consecutive? (Are the AFDs in a row?)	
Smoking history? Please detail	
YOUR BIRTH:	
We're you delivered vaginally or c-section?	
Were you breast fed?	
If so, for how long? If not, which kind of formula?	
HEALTH HISTORY:	
Can you please list ALL previous medical diagnosis you have had throughout your life?	
FAMILY HEALTH HISTORY:	
Please list any illnesses members of your close blood family have experienced eg. Cardio vascular disease, asthma, cancer, diabetes, arthritis	
Mother:	
Mother's Mother:	
Mother's Father:	
Father:	
Father's Mother:	
Father's Father:	
Siblings:	

YOUR DENTAL HEALTH	
Do you have fillings? If so, how many/ what type?	
Do you have root canals or implants or crowns?	
Do you clench or grind your jaw in the evenings?	
Please describe other dental problems.	

YOUR SLEEP				
How would you describe your recent sleep patterns? (delete non-applicable descriptions)				
Total Insomnia	**Difficulty falling asleep**	**Difficulty staying asleep/ waking early am**	**Fall asleep straight away/sleep sound**	**Other (describe)**
Average hours of sleep a night				
How do you feel on waking in the morning?				

YOUR EXERCISE					
How would you describe your current exercise strategy? Please include types of exercise and activity you do regularly.					
Minutes per session:		**Number of sessions / week**		**Intensity** high/med/low	
Do you have any injuries preventing your from					

exercising?	

YOUR RELAXATION				
What kind of relaxation techniques do you currently use? (delete non-applicable descriptions)				
Listening to music	**Being in nature**	**Time with a pet**	**Meditation**	**Breathing practice**
Yoga	**Pilates**	**Quiet time**	**Prayer**	**Other**
How many days a week do you practice relaxation techniques?				

MENOPAUSAL RATING SCALE (MRS) – Standardised questionnaire to identify severity					
Which of the following symptoms apply to you at this time? Please mark the appropriate box for each of the symptoms listed below. For any symptoms that do not apply, please mark 'none'.					
SYMPTOMS	**None=0**	**Mild=1**	**Moderate=2**	**Severe-3**	**Very Severe=4**
1. Hot flushes, sweating (episodes of sweating)					
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)					
3. Sleep problems (difficulty falling asleep, difficulty sleeping through, waking early)					
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)					
5. Irritability (feeling nervous, inner tension, feeling aggressive)					
6. Anxiety (inner restlessness, feeling panicky)					
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)					
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)					
9. Bladder problems (difficulty urinating, increased need to urinate, bladder incontinence)					
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)					
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)					
TOTAL SCORE					

How committed are you to achieve your health aims? **1= kind of. 10 = totally committed**	
If you need supplements, do you have an ideal Budget $ per week for your treatment?	
Are there any further concern you would like to note? (to discuss in more detail during your consultation)	
Any recent blood test results of scans to share? Please mention these here. Ideally sharing copies of these prior to your consultation is helpful.	

Please email your completed form to smile@soundmedicine.com.au before your appointment.

Thank you for committing to your wholistic wellbeing.