Global Health Clinics
HOLISTIC HEALTH CARE

New Client Details

Date: / /

Name: Mr/Mrs/Ms			D.o.B: / /	Age:
Address:			Occupation:	
			Ethnicity:	
Email:			Gender: M F	
Telephone:	(Home)	(Work)	(Cell)	
No. Children:	Boys:	Girls:	Marital Status:	
Occupation:	Hrs worked/wk			
Guardian's Name (if client a Child):				
General Practitioner:				

I, ... agree to undergo consultation with a practitioner at Global Health Clinics, or with our authorised locum, on the following terms.

All personal information gathered from me will be kept confidential under the Privacy Act, and any other laws of New Zealand. I agree for information being used, anonymously, for the purpose of advancement of knowledge, for example for teaching or as statistical data.

I maintain the right to refuse any examination or treatment that I do not wish to have. I agree that I will make every attempt to comply with any treatment I do accept, or I will discuss the reasons for this with the practitioner or with GHC management.

Global Health Clinics, or an authorised locum do not make any medical diagnoses, nor makes any claim to "cure" specific diseases. No attempt will be made to interfere with or recommend changes to medical treatment prescribed by a medical doctor. Global Health Practitioners make health assessments according to scientific principles. Global Health Clinics use holistic methods to assist clients to regain or improve their health.

Global Health Clinics practitioners use every care with the quality and appropriateness of neutraceutical preparations and therapies, I accept that, very rarely, there may be unexpected reactions. In that situation, I accept full responsibility for any adverse reactions and will inform my practitioner at the earliest possible time.

I take personal responsibility for my condition, and for the treatment and ongoing maintenance with the support of Global Health Clinics, its practitioners and authorised locums.

In accordance with legal requirements, I absolve Global Health Clinics and its practitioners from adverse reactions arising from non-disclosure of any medication or medical conditions.

Signed:..... Date:.....

☐ Please indicate if you prefer not to receive further information and GHC newsletters

Global Health Clinics uses a best practice model and complies with the Health & Disabilities Act 1994

www.globalhealthclinics.co.nz

NB: GHC has a 24 hour cancellation policy

Global Health Clinics 5 Anzac Street, Takapuna, ph:(09) 488 0208

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Health and Well-Being Form

Please fill in this questionnaire so we can establish what your health and wellbeing priorities are. As a holistic practice we see health as a mind-body-spirit issue and the information given here will help your practitioner formulate a specific treatment plan for you to achieve your health goals.

1	Why have you come to Global Health Clinics?

2	Have you ever had similar challenges before, and if so, when?

3	List any daily activities you are finding difficult, or are limited as a result of this issue(s):

4	Please list any other healthcare professionals you are seeing for this or other problem(s). Please give their names and modality:

5	Please list any medical tests or scans you have had in the last 12 months:

6	What are your goals from consulting Global Health Clinics practitioner(s)?

7a	List any prescribed medication that you are currently taking or have taken regularly in the past:
7b	List any natural dietary supplements that you are currently taking or have taken regularly in the past:

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8	Past medical history (previous injuries, accidents, surgeries, traumas, loss of consciousness, child-hood illnesses, etc. Please describe and include approximate dates: *(Use back if needed)*

9	Circle any vaccinations you have had: polio influenza meningitis tuberculosis tetanus
	hepatitis A / C triple vacs diphtheria/whooping cough/tetanus measles/mumps/rubella
	Other vaccines (specify)

10	Do you or your family members (eg parent or sibling) have a history of (please circle)
	Mental Illness Addiction Emotional Traumas Cancer Heart Disease Diabetes
	Arthritis Asthma/Eczema Relationship Conflict/Divorce Adoption

10a	Were you breast-fed? Yes No For how long? mnths
10b	Would you see your outlook as..... Religious Spiritual Agnostic Atheist Scientific

11a	Women's Health Menstrual Cycle: Regular every_____days Irregular
	Do you get PMT? Always Sometimes Never
	What type of contraception do you use?
	About Menopause are you: Pre Peri Post

11b	Men's Health
	How many times do you get up at night to urinate? 0 1 2 3 4 more
	Is urination painful? Yes No

12	How do you rate your sleep on scale 1 - 10?	(poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
13	Do you suffer ongoing depression?	(mild) 1 2 3 4 5 6 7 8 9 10 (severe)
14	How do you rate your energy on scale 1 - 10?	(poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
15	Are you continually tired and underpar?	(never) 1 2 3 4 5 6 7 8 9 10 (severe)

16	What do you do to relax, ie hobbies, meditation, etc?
	How much time do you have for yourself to relax? hrs/week When?

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Health and Well-Being Form

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What kind of exercise do you do?	
How long do you spend per day?	hrs
How many times per week do you do this?	

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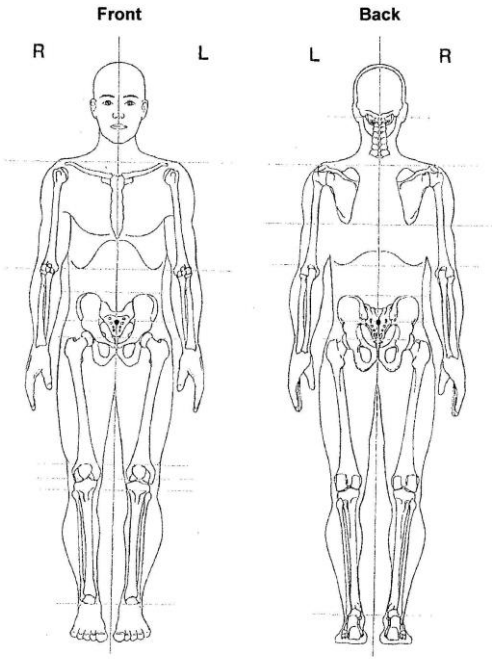
Please mark best description for level of stress				
Family stress:	None	Minimal	Moderate	Severe
Relationship stress:	None	Minimal	Moderate	Severe
Work stress:	None	Minimal	Moderate	Severe ss:
Financial stre	None	Minimal	Moderate	Severe
Health stres:	None	Minimal	Moderate	Severe s:
Other Stres	None	Minimal	Moderate	Severe

19. On the diagram below please mark any area and level of pain or discomfort with a circle using a scale of 1 - 10

1 = Slight awareness of discomfort
2-3 = Awareness of discomfort as an aggravation
4-6 = Pain is strong but you are still functional
7-9 = Pain is so strong you are unable to function normally
10 = Unbearable



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Rate any of these feelings you have experienced in the last few months on scale 1 (not at all) to 5 (extreme)					
Abused	1	2	3	4	5
Criticized	1	2	3	4	5
Overworked	1	2	3	4	5
Paralysed	1	2	3	4	5
Depressed	1	2	3	4	5
Rejected	1	2	3	4	5
Despaired	1	2	3	4	5
Helpless	1	2	3	4	5
Hopeless	1	2	3	4	5
Paranoid	1	2	3	4	5
Overwhelmed	1	2	3	4	5
Muddled	1	2	3	4	5
Persecuted	1	2	3	4	5
Guilty	1	2	3	4	5
Easily irritated	1	2	3	4	5
Anxious	1	2	3	4	5
Sad	1	2	3	4	5
Grieving	1	2	3	4	5
Unable to grieve	1	2	3	4	5
Apprehensive	1	2	3	4	5
Agitated	1	2	3	4	5
Uneasy	1	2	3	4	5
Distressed	1	2	3	4	5
Fearful	1	2	3	4	5
Impatient	1	2	3	4	5
Intimidated	1	2	3	4	5
Restless	1	2	3	4	5
Panic	1	2	3	4	5
Intolerant	1	2	3	4	5
Uncertainty	1	2	3	4	5
Aggravated	1	2	3	4	5
Annoyed	1	2	3	4	5
Angry	1	2	3	4	5
Outraged	1	2	3	4	5
Nervous	1	2	3	4	5
Worried	1	2	3	4	5

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Your current diet sheet.

Breakfast: (please specify if missed how many times per week)

Mid am:

Lunch:

Mid pm:

Dinner:

Supper (if any):

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Please indicate amounts of the following per day / week as frequency determines:

Coffee:

Soft Drinks / Energy drinks (please specify):

Alcohol:

Marijuana:

Chocolate:

Sugary Snacks / lollies / junk food:

Cigarettes: (rollies / manufactured)

Quantity of PURE water drunk daily (if at all)**:**

Deep fried foods:

Pan fried foods:

Stir fried foods:

Red meats:

White meats:

Fish meals:

Vegetarian meals: