Britt Barkman
Naturopath | Medical Herbalist

Clinical Naturopath www.brittbarkman.com.au

Patient Intake

Date: _____ Surname: _____

Mr Mrs Ms Miss (please circle) First Name: _____

ADDRESS: _____ PH (H): _____

_____ Postcode:_____ PH (M/W): _____

Date of Birth: _____ Age:_____ Email:_____

Occupation: _____ Receive Newsletters & emails? Yes ☐ No ☐

Marital status: _____ Health Fund:_____

Next of Kin OR Name of Parent or guardian if under 16yrs:

_____

What is the main reason for you visit?

_____

_____

_____

_____

Please list ANY *medicines* or *supplements* you are taking.

Include those from the doctor, other practitioners, the health food store, the pharmacy or supermarket.

_____

_____

_____

_____

_____

Brief Family History: (Please tick any of the following conditions that you or your family may have or have had)

	Self	Family		Self	Family
Alcoholism	☐	☐	Allergies	☐	☐
Asthma/bronchitis	☐	☐	Arthritis	☐	☐
Cancer	☐	☐	Hayfever	☐	☐
Heart disease/stroke	☐	☐	High blood pressure	☐	☐
Nervous disorders	☐	☐	Migraine headaches	☐	☐
Skin disorders	☐	☐	Obesity	☐	☐
Thyroid disease	☐	☐	Diabetes	☐	☐
Epilepsy	☐	☐	Hepatitis	☐	☐
Depression	☐	☐	Eating Disorders	☐	☐
Other	☐	please specify:_____			

_____

Britt Barkman
Naturopath | Medical Herbalist

Do you have any allergies, intolerances or life threatening conditions?

Please specify:_____

_____

_____

Weight: _____ Height:_____

Where did you hear about us?
- ☐ Yellow pages online
- ☐ Website
- ☐ Flyer
- ☐ Natural Therapy Pages
- ☐ Google search
- ☐ Friend (name so we can thank them)
- ☐ Other _____

Permission to contact Dr if necessary:

☐yes ☐no

Doctor: _____

PH:_____

Are you under the care of a medical specialist for any conditions?

☐yes ☐no

_____

Have you visited a naturopath or herbalist before?

☐yes ☐no

If so what sort of treatment did you have?_____

_____

What made you discontinue treatment?_____

_____

Are you receiving treatment from any other health professional?

☐yes ☐no

i.e. chiropractor, physiotherapist, kinesiologist, fitness instructor etc

Name of practitioner_____

Type of treatment_____

The information I have given is to the best of my knowledge accurate and I will provide any additional information that may come to my attention.

I understand that I am responsible for informing the practitioner of any medications I am currently taking, and that any changes or additions must be reported as they occur.

I am aware that any information I provide is private and confidential and will not be passed on to any third parties without my permission.

I understand that this is not a medical practice and Britt Barkman is not a medical practitioner.

Patient (or Guardian) Signature. _____ Date_____