# WELCOME TO AKAAL HEALING

**Please complete the questionnaire as comprehensively as you can.**
**To best treat you, we need to collect information which is sometimes personal and highly private.**
**Please be assured that this form is confidential and the details you give us will not be shared unless your permission is initially sought.**

**Date:**

**Your Full Name**

**Street Address**

**Suburb**

**State**

**Postcode**

**Phone**

**Email**

**Date of Birth**

**Gender**

**Male** - □ (male)
**Female** - □ (female)
**Transgender** - □ (transgender)
**Not specified** - □ (unspecified)

**How did you hear of BICOM Therapy?**

**Psychiatrist / Psychologist (if applicable)**

**Emergency Contact**

**Emergency Phone**

**Current Medications**

**Current Supplements**

## MAIN COMPLAINT

**Please describe your main complaint**

**What are your symptoms and areas affected?**

**When did your symptoms start?**

**What was happening at the time? (include life events, no matter how unrelated they seem to you)**

**Have you received other treatments in the past? If yes, please list:**

**Which treatments improved symptoms?**

**Which treatments made symptoms worse?**

**Have you been diagnosed with any of the following conditions?**

**Lupus** - ☐ (Lupus)

**Multiple Sclerosis** - ☐ (Multiple Sclerosis)

**Underachieve or Overactive thyroid** - ☐ (Underachieve orOveractive thyroid)

**Rheumatoid Arthritis** - ☐ (Rheumatoid Arthritis)**Sjogren's Syndrome** - ☐ (Sjogren's Syndrome) **Scleroderma** - ☐ (Scleroderma)

**Pernicious Anaemia** - ☐ (Pernicious Anaemia)

**Vitiligo (patchy skin pigmentation)** - ☐ (Vitiligo (patchy skin pigmentation))

**Please list any medical conditions diagnosed:**

**Have you ever had surgery? If so, please list**

**Have you ever been involved in an accident? If so, p;ese list what type, dates and outcomes - include fractures, head or spine knocks and scars**

**Have you received vaccinations? If so, please list**

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**Do you have any skeletal problems? If so, please list**

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**Do you have any digestive problems? If so, please list**

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**Do you have any circulatory problems? If so, please list**

**How would you describe your blood pressure?**

**Balanced** - ☐ (Balanced)

**High** - ☐ (High)

**Low** - ☐ (Low)

**Do you have any problems with fluid retention? If so, please list**

**Do you have any problems with the nervous system, such as tension headaches, neck or shoulder pain? If so, please list:**

**Do you have any history of anxiety or panic attacks? If so, please list:**

**Do you experience frequent sinus/coughs/colds? If so, please list:**

**Do you have skin problems? If so, please list:**

**Have you ever been diagnosed with cancer? If so what type and when:**

.

**Do you have any of the following:**

**Heart pacemaker** - □ (Heart pacemaker)

**Hearing aid** - □ (Hearing aid)

**Metal implants** - □ (Metal implants)

**Metal fragments within your body** - □ (Metal fragments within your body)

**If metal implants or fragments, where are they?**

## FOR WOMEN

**Are You Pregnant or Trying to Become Pregnant?**

**Yes** - □ (yes)

**No** - □ (no)

**Do you have any problems with your menstrual cycle? If so, please list**

**Do you have endometriosis? If so, when was it diagnosed?**

**Do you have fibroids? If so, when were you diagnosed?**

**Do you wear tampons? if so, are they organic?**

**Type of contraception used:**

**Oral (The pill)** - □

**Coil/Mirena/IUD** - □

**Hormone Implant** - □

**None of hormonal origin** - □

**Do you use HRT?**

**Yes** - □ (Yes)

**No** - □ (No)

## LIFESTYLE

**DIET**

**Please tick as many boxes as appropriate:**

**Vegan** - □

**Vegetarian (eggs and dairy)** - □

**Vegetarian (fish)** - □

**Soy and tofu** - □

**Pork/bacon** - □

**Wholemeal grains** - □

**White bread/flour/rice** - □

**Added sugar** - □

**Dairy and Milk** - □

**Beef**

**Grass fed/free range** - □

**Grain fed** - □

**Organic** - □

**Non organic** - □

**I don't eat beef** - □

**Chicken**

**Organic** - □

**Non organic** - □)

**I don't eat chicken** - □

**Do you eat any tinned food? If so, please list**

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**Do you have any food allergies or intolerances? If so, please list**

## RECREATIONAL DRUGS

**Do you drink alcohol?**

**I don't drink alcohol** - ☐ (I don't drink alcohol)

**Rarely** - ☐ (Rarely)

**1-2 times per week** - ☐ (1-2 times per week)

**3-5 times per week** - ☐ (3-5 times per week)

**Every day** - ☐ (Every day)

**How many standard drinks would you have per day?**

**I don't drink alcohol** - ☐ (I don't drink alcohol)

**1-2 drinks** - ☐ (1-2 drinks )

**3-5 drinks** - ☐ (3-5 drinks )

**More than 6 drinks** - ☐ (More than 6 drinks)

**Do any of your immediate family suffer from alcoholism?**

**No** - ☐ (No)

**Yes** - ☐ (Yes)

**Do you smoke? How many cigarettes per day?**

**I don't smoke** - ☐ (I don't smoke)

**Less than 5 cigarettes** - ☐ (Less than 5 cigarettes)

**5 - 10 cigarettes** - ☐ (5 - 10 cigarettes)

**10 - 20 cigarettes** - ☐ (10 - 20 cigarettes)

**20+ cigarettes** - ☐ (20+ cigarettes)

**Do you use weed/marijuana/cannabis**

**No** - ☐ (No)

**Yes** - ☐ (Yes)

**Do you use any other recreational drugs? If so, please list**

## EXERCISE

**Do you exercise? How often?**

**I don't exercise** - ☐ (I don't exercise)

**Less than once per week** - ☐ (Less than once per week)

**2-5 times per week** - ☐ (2-5 times per week)

**Over 5 times per week** - ☐ (Over 5 times per week)

**Type of exercise (please list all activities):**

## SLEEP

**How many hours night-time sleep do you get:**

**How many hours day-time sleep do you get:**

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**How is your sleep pattern?**

**Continuous** - □

**Broken** - □

**Reason for waking:**

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**How many times would you wake per night?**

**Can you get back to sleep?**

**Yes** - □

**No** - □

**Do you feel refreshed in the morning?**

**Yes** - □

**No** - □

## DENTAL

**Do you have/have you had any of the following:**

**Amalgam (silver) fillings** - □ (Amalgam (silver) fillings)

**Gold or silver teeth** - □ (Gold or silver teeth)

**Root canal surgery** - □ (Root canal surgery)

**Wisdom teeth extracted** - □ (Wisdom teeth extracted)

**Caps/crowns/bridges/implants** - □

(Caps/crowns/bridges/implants)

**Dentures** - □ (Dentures)

## OTHER

**Have you ever been bitten by a tick?**

**Yes** - □ (Yes)

**No** - □ (No)

**If yes, when?**

**Do you have any known allergies?**

**Yes** - □ (Yes)

**No** - □ (No)

**If yes, what substance and reactions:**

**Do your parents have any known allergies?**

**Yes** - □ (Yes)

**No** - □ (No)

**Do you have any tattoos?**

**Yes** - □ (Yes)

**No** - □ (No)

**Do you have any piercings?**

**Yes** - □ (Yes)

**No** - □ (No)

**Do you have any hobbies?**

**Yes** - □ (Yes)

**No** - □ (No)

**If yes, what are they:**

**Does anyone in your family suffer from the herpes virus/cold sores/shingles?**

**Yes** - □ (Yes)

**No** - □ (N

## PRIVACY STATEMENT

**At *AKAAL NATURAL THERAPY,* we respect yourprivacy. To provide you with the highest standardof holistic care, it is necessary to collect personal information from you such as that requested in this form and held in your personal treatment file. Without thisinformation, we will not be able to plan an ultimate treatment package for you. Understandably, some of the requested information is of a personal or private nature. The sort that you would not wish to disclose to others. We value the necessity of safeguarding this information,**

**therefore, we would like to assure you of the following:**

- **The information will only be used by us, your health care practitioners, in order to deliver you the highest standard of holistic care. It will not be disclosed to those not associated with your treatment without your express consent.**
- **You may seek to access the information held about you. We will provide this gladly without delay. Should you require a copy of any of this information, this will be attended to within seven (7) days of your requestif possible. This service is available free of charge unless you request hard copies of your records. The fee charged will cover associated costs of processing and copying this information.**
- **We will always take steps to ensure all information will be kept current, accurate and complete.**
- **We will always take all reasonable caution to protect your information from misuse, loss, access by unauthorized persons, modification, or disclosure.**
- **Please also note that as your practitioner, whilst doing the very best to help you on your health journey, I am not able to diagnose conditions, such as cancer, which may require the utilisation ofconventional diagnostic methods such as ultrasounds,MRIs and PET scans etc.**

**I have read and agree with the above privacy statement:**

**Yes** - □ (Yes)

**No (Please note that we will be unable to treat you if you check this box)**

- □ (No)

# CANCELLATION POLICY

**A reminder SMS will be sent to you 2 days prior yourappointment.**

**This is a courtesy only. You are responsible for your appointment and if you are unable to attend, please call to reschedule or cancel as per our cancellation policy. Occasionally there are hiccups in our system and the reminders may not be sent. Please note that we are not responsible if you forget your appointment due to you relying on this reminder.**

**Thank you for understanding.**

**AKAAL HEALING is a very busy clinic. We require minimum 48 hours' notice to cancel an appointment as this allows us time to fill that space. If you cancel on the day of your appointment or give us less than 48hrs notice you will be charged a cancellation fee of the cost of the appointment. If you decide to re-schedule 50% of the fee will be subtracted. Time slots can be hard to fill at the last moment.**

**This is a courtesy to all involved.**

**Of course, emergencies happen and if there is a valid reason for your short cancellation, we will waive this fee.**

**I have read and agree with the above cancellation policy:** **Yes** - ☐ (Yes) Signature : Date:

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