

THE MOJO KLINIK



Confidential Patient Questionnaire

THE MOJO KLINIK

Please list your reasons for this appointment (problems you are experiencing)

What do you believe this is due to?

Have you tried any treatment(s) for problem(s) listed above? If so, please include any relevant test/consults/ investigation/letters to your appointment

When was the last time you felt well?

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| What do you expect from your consultation today? |
| |

Medical History

Please circle what is relevant to you

| Illness/Medical Problem | Present | Past |
|---|---------|--------|
| Heart/Vascular Disorder | YES | YES |
| Blood Disorder | YES | YES |
| High Blood Pressure | YES | YES |
| Cancer | YES | YES |
| Arthritis | YES | YES |
| Diabetes | YES | YES |
| Liver Disease | YES | YES |
| Kidney Disease | YES | YES |
| Asthma | YES | YES |
| Epilepsy | YES | YES |
| Hepatitis | YES | YES |
| Glandular Fever | YES | YES |
| Dysentery | YES | YES |
| Sexually Transmitted Diseases (please specify) | YES | YES |
| Other Conditions (please specify) | YES/NO | YES/NO |
| Operations (please specify) | YES/NO | YES/NO |
| Exposure to chemicals or Toxins (please specify) | YES/NO | YES/NO |
| Pregnancies | YES/NO | YES/NO |
| Amalgam Fillings | YES/NO | YES/NO |
| Frequent Antibiotic use | YES/NO | YES/NO |
| long term medications (includes contraceptive pill) | YES/NO | YES/NO |

Pathology & Screening History

| Screening Test/Pathology | Date | Result |
|------------------------------|------|--------|
| Mammogram/ Breast Ultrasound | | |
| Pap Smear | | |
| Bone Density | | |
| Cholesterol | | |
| PSA (Prostate Blood Test) | | |

Nutritional Supplements (vitamins, minerals etc.), Herbal Medicines, Homoeopathic Remedies

| Name | Dosage |
|------|--------|
| | |

Current Medications (prescription & non-prescription)

| Name | Dosage |
|------|--------|
| | |

Allergies & Sensitivities (including medications, food, dust mites, grass, chemicals etc.)

| Allergies/Sensitivities | Treatment |
|-------------------------|-----------|
| | |

Social History

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|---|--|
| Occupation | |
| Marital Status | |
| Cigarettes/ Tobacco (strength & amount per day) | |
| Alcohol (type & amount per day) | |
| Recreational Drugs | |
| Exercise (type, duration & frequency) | |
| Relaxation Techniques (Meditate, read, yoga etc.) | |

Diet

| Do you follow a specific type of diet? | YES/NO |
|--|--------|
| If yes, please specify(e.g. low fat, blood group, vegetarian etc.) | |

What did you eat yesterday?

| | | |
|--------------------------------|-----------------------------|----------------------|
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks | | |
| Sugar(tsp/day) | Tea OR Coffee (cups/day) | Soft Drinks(per day) |
| Water (amount/glasses per day) | Other drinks | |

Was this a typical day?

YES/NO

| Please list foods that you crave | Please list foods that you avoid |
|---|---|
| | |

Immunisation History (Please record any immunisations you have received)

| TYPE | DATE | TYPE | DATE |
|------|------|------|------|
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Current Symptoms

Please tick the box to the right of any condition(s) you are **currently experiencing**

General

- Fatigue
- Apathy/Lethargy
- Hyperactivity
- Poor Appetite
- Hypoglycaemia
- Poor Sleep/insomnia
- Sleep apnoea
- Excessive thirst
- Stress
- Easy Bruising

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Weight

- Weight gain
- Difficulty losing weight
- Fluid retention
- Binge eating
- Compulsive eating
- Craving for certain foods
- Aversion of certain foods
- Weight loss
- Eating disorders

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Nervous System

- Headaches
- Migraines
- Faintness
- Dizziness
- Numbness
- Tingling, pins & needles
- Poor co-ordination
- Feel cold easily
- Cold hands & feet

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Eyes

- Water/itchy
- Painful/red
- Sticky eyes
- Blurred vision
- Losing vision
- Dry eyes

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| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Ears

- Itchy
- Aches
- Infections
- Discharge
- Tinnitus
- Ringing
- Hearing loss

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Digestive System

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|------------------|--------------------------|
| Indigestion | <input type="checkbox"/> |
| Heartburn/reflux | <input type="checkbox"/> |
| Bloating | <input type="checkbox"/> |
| Feel full easily | <input type="checkbox"/> |
| Burping | <input type="checkbox"/> |
| Flatulence | <input type="checkbox"/> |
| Abdominal pain | <input type="checkbox"/> |
| Stomach cramps | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> |
| Vomiting | <input type="checkbox"/> |
| Hard to swallow | <input type="checkbox"/> |
| Diarrhoea | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> |
| Haemorrhoids | <input type="checkbox"/> |
| Mucus | <input type="checkbox"/> |
| Rectal bleeding | <input type="checkbox"/> |
| Anal itching | <input type="checkbox"/> |

Gynaecological

| | |
|--------------------|--------------------------|
| PMS/PMT | <input type="checkbox"/> |
| Breast Pain | <input type="checkbox"/> |
| Breast Lumps | <input type="checkbox"/> |
| Breast implants | <input type="checkbox"/> |
| Regular periods | <input type="checkbox"/> |
| Irregular periods | <input type="checkbox"/> |
| No periods | <input type="checkbox"/> |
| Heavy periods | <input type="checkbox"/> |
| Menstrual clots | <input type="checkbox"/> |
| Period pain | <input type="checkbox"/> |
| Intercourse pain | <input type="checkbox"/> |
| Vaginal soreness | <input type="checkbox"/> |
| Vaginal irritation | <input type="checkbox"/> |
| Discharge | <input type="checkbox"/> |
| Thrush | <input type="checkbox"/> |
| Menopausal | <input type="checkbox"/> |
| Hot flushes | <input type="checkbox"/> |
| Sweats | <input type="checkbox"/> |
| Vaginal dryness | <input type="checkbox"/> |

Heart/Circulation

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|-------------------------|--------------------------|
| High blood pressure | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> |
| High cholesterol | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> |
| Palpitations | <input type="checkbox"/> |
| Arrhythmia | <input type="checkbox"/> |
| Swelling of ankles | <input type="checkbox"/> |
| Poor circulation | <input type="checkbox"/> |
| Calf pain with exercise | <input type="checkbox"/> |
| Varicose veins | <input type="checkbox"/> |

Lungs

| | |
|-----------------|--------------------------|
| Short of breath | <input type="checkbox"/> |
| Cough | <input type="checkbox"/> |
| Sputum | <input type="checkbox"/> |
| Blood | <input type="checkbox"/> |
| Chest tightness | <input type="checkbox"/> |
| Wheeze | <input type="checkbox"/> |

Genito-Urinary

- Frequent urination
- Passing large amounts of urine
- Burning during urination
- Discomfort during urination
- Discharge
- Blood in urine
- Urgent urination
- Kidney Pain
- Difficulty passing urine
- Passing urine frequently at night
- Incontinence
- Loss of libido
- Erectile dysfunction/ impotence

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Joints & Muscles

- Pain
- Swelling
- Stiffness
- Arthritis
- Neck problems
- Back problems
- Cramps/spasms
- Muscle twitching
- Muscle tension
- Weak muscles
- Gout

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Skin

- Acne/pimples
- Eczema
- Dermatitis
- Psoriasis
- Rosacea
- Rashes
- Hives
- Dry skin
- Poor healing
- Excessive sweat
- Body odour
- Dandruff

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Hair & Nails

HAIR

- Dry hair
- Hair loss

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NAILS

- Soft
- Break easily
- White spots
- Ridged
- Fungal infection

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Mouth & Throat

- Mouth ulcers
- Cold sores
- Mouth cracks(corners)
- Sore throat
- Hoarseness
- Loss of voice
- Gum disease/bleeding
- Feeling of lump in throat
- Loss of taste sensation
- Bad breath

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Nose

- Congested
- Blocked
- Poor sense of smell
- Sinus problems
- Hay fever
- Allergies
- Sneezing
- Excessive mucus
- Post-nasal drip

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Emotions

- Anxiety
- Depression
- Mood swings
- Panic attacks
- Anger
- Irritability

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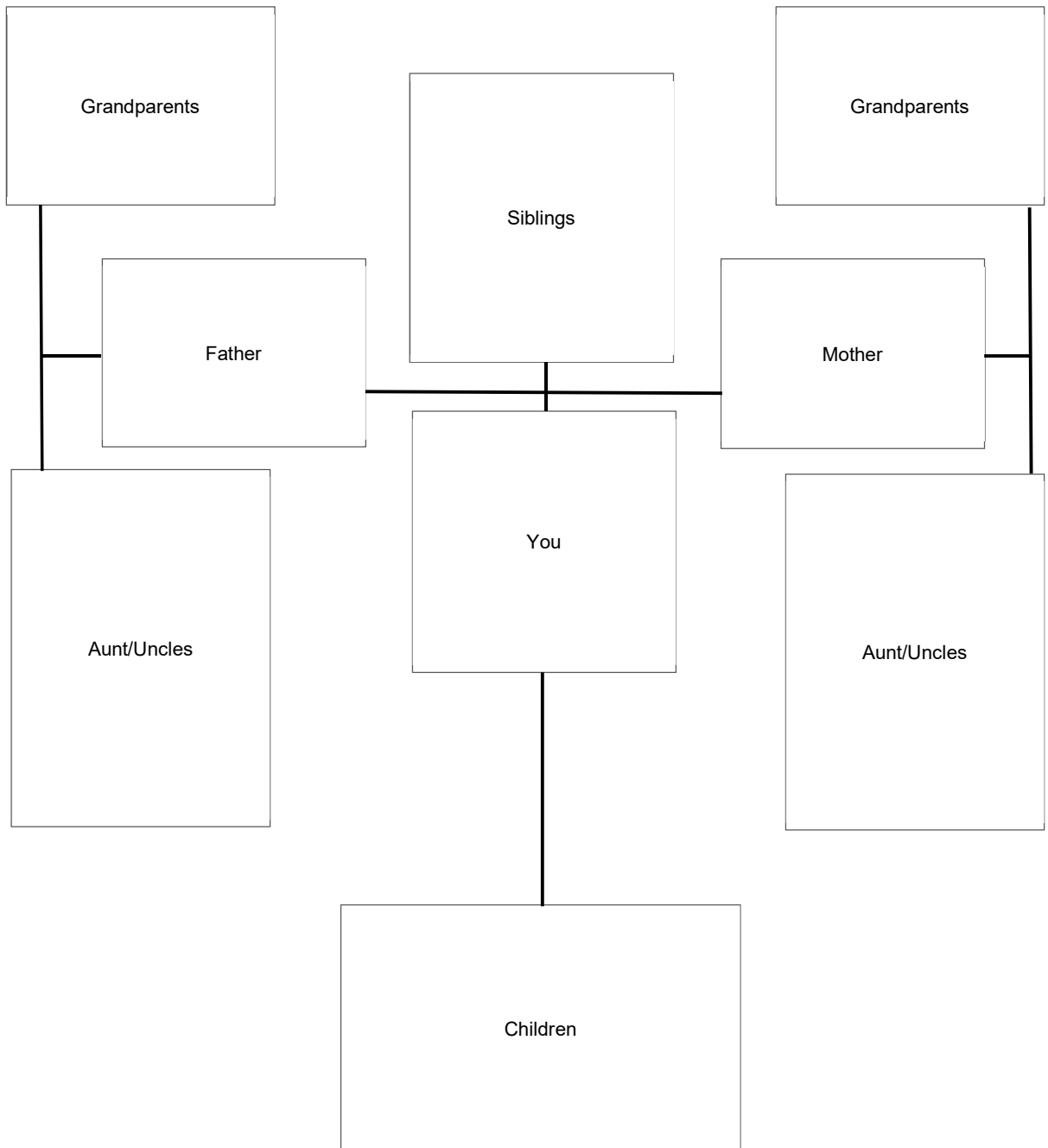
Mind

- Poor memory
- Poor concentration
- Confusion
- Poor comprehension
- Brain fog

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Family History

Please complete the chart below indicating only chronic or significant illnesses (e.g. diabetes, asthma, cancer, arthritis, heart disease, blood pressure etc.) within the appropriate box on the family medical history tree below.



General Acknowledgement & Consent Form

I,

of

(address)

understand that some of the diagnostic test, treatments & products administered by practitioners at The Mojo Klinik may be outside the parameters of conventional medicine in Australia. They fall into the category of Natural or Complementary Medicine. I understand that these diagnostic tests, treatments and products are supported by empirical knowledge are safe, are widely & successfully used by Integrative Medical practitioners in centres in Australia & overseas, and are only prescribed with the utmost care. Some diagnostic tests & treatments offered at The Mojo Klinik are not covered by medicare or private health insurance funds. All Mojo Klinik practitioners are members and active participants of their respective professional Colleges & Associations.

I am attending The Mojo Klinik of my own free will & consent, and exercise my right to discuss * choose any useful & suitable treatment(s) made available to me. I understand that Mojo Klinik practitioners may recommend & dispense items that are yet to be regulated by Therapeutic Goods Administration (TGA), should the practitioner deem that such products or treatments are in my best interest. If there are any risks associated with using unregulated products or treatments, The Mojo Klinik practitioner(s) will make me fully aware of those risks & provide me with sufficient information to make an informed decision.

Patients Name:

Witness's Name:

Signature:

Signature

Date:

Date:

