Thank you for your enquiry.

The first step is to complete this Application so that I can prepare all your case prior to our appointment. Once you have done this please save the form and email it to me as an attachment to kathryn@kathrynalexander.com.au If you have a chronic condition or cancer please send medical reports, such as blood tests, scan reports or histology reports that confirm the diagnosis or give greater insight into your current condition. MEDICAL CONFIDENTIALITY IS ASSURED.

Once I have received your information I will contact you for an appointment.

**CANCELLATIONS**

Appointments that are cancelled less than 24 hours of the agreed appointment time (or 48 hours for cancellations on a Monday)

will be charged at half the rate, and missed appointments will also be charged at half the rate.

Consultations are conducted via Zoom, which can be downloaded as a free App. If you don’t already use Zoom then here are some instructions:

To sign up and download the free software on any PC or Mac computer this is the link

<https://zoom.us/signup>

If you have an Apple phone or iPad then you download the free app from the Apple Store

<https://itunes.apple.com/au/app/zoom-cloud-meetings/id546505307?mt=8>

If you have an Android  (non Apple phone or pad) you get the free app from the Android store (play store)

<https://play.google.com/store/apps/details?id=us.zoom.videomeetings&hl=en_AU>

I would recommend that you download the software at your convenience so that you can test everything, using the links above, well before the appointment. You need to also check your preferences to make sure that your audio is on, and also click the start video button.

Please indicate your preferred method of payment on the form and provide details.

Once you completed the application, save as a file on your computer and send as an attachment via email to kathryn@kathrynalexander.com.au

**Unfortunately, hand-written forms cannot be accepted.**

Warm Regards

Kathryn Alexander

|  |
| --- |
| **PROFILE** |
| Current date |       |
| Name and Title |       |
| Sex (Male/Female) |       |
| e-mail address |       |
| Contact telephone | Telephone       |
| Preferred method of payment | [ ]  Direct Debit (Australia only) |  |
| [ ]  Credit card (Visa or Mastercard only) | Card number:      Expiry:      CVV:       |
| What is your date of birth? |       |
| What is your current age? |       |
| What is your weight? |       |
| What is your height? |       |
| Please indicate if you are you a principle carer for others, including family members? If so, how many dependents do you care for? | Principle carer: Y/N      Number of dependents       |
| **GENERAL HEALTH** |
| How much does your general health (physical and mental) impact your life on a scale of 1-10 where 1 = no impact at all and 10 = very high impact | *Score*  |
| Can you describe some of the difficulties your health creates for you? |       |
| Where would you most like to see change? |       |
| **GENERAL STRESS** |
| Can you score the impact of stress on your life where 1 = no impact at all and 10 = very high impact | *Score*  |

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| **CURRENT STATUS** |
| Please add your diagnosed conditions in the table below. Add your medications, symptoms, and if you are being monitored by your doctor, what they may be testing. You may also be aware of future health risks for each condition and you can add the ones which concern you. If you do not have a diagnosis then please go to the next section. |
| **Diagnoses**  | **Medications / Surgeries** | **Symptoms***List main symptoms for each diagnosis.* | **Tests***Are any of your conditions being monitored with tests? If so what is being tested?* | **Future health risks***List future health risks that you are concerned about for each diagnosis* | **Does this condition run in the family?** |
| Diagnosis:      Year of diagnoses:       |       |       |       |       | Y/N       |
| Diagnosis:      Year of diagnoses:       |       |       |       |       | Y/N       |
| Diagnosis:      Year of diagnoses:       |       |       |       |       | Y/N       |
| Diagnosis:      Year of diagnoses:       |       |       |       |       | Y/N       |
| Diagnosis:      Year of diagnoses:       |       |       |       |       | Y/N       |
| Diagnosis:      Year of diagnoses:       |       |       |       |       | Y/N       |
| **CURRENT SYMPTOMS** |
| Add any other symptoms that are reducing your quality of life below, including those that do not belong to a fixed diagnosis. |
| **LIST SYMPTOMS**Add more lines under each body part, if required | **Does anything make this symptom worse?***This may include stress, weather changes, specific foods/drinks, being run down etc.* | **Do you take anything or do anything that helps this symptom?***This may include over-the-counter medicines, herbs, homeopathics, first aid or even self-aid.* | **How long have you had this symptom for?** |
| **Head and neck***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
|       |       |       |       |
| **Chest***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
| **Abdomen – upper and lower***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
| **Urinary system***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
| **Arms, legs and back***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
| **General physical/mental/emotional***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
| **Female reproductive***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
| **Male reproductive***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |

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| **MEDICAL HISTORY** |
| Please scroll through this section and check the conditions you have had in the past, their duration (years/months) and any treatments taken. Select if they are also current. |
| **Cancer***If you have you been diagnosed with any cancers in the past specify which ones and when, also what treatments were undertaken.* | Year of diagnosis | Treatments undertaken  |
|       |       |       |
|       |       |       |
| **DIGESTIVE SYSTEM**  | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Cirrhosis |       |       |  [ ]  |       |
| Non-alcoholic fatty liver disease |       |       | [ ]  |       |
| Gall stones |       |       | [ ]  |       |
| Hepatitis |       |       | [ ]  |       |
| Jaundice |       |       | [ ]  |       |
| Pancreatitis |       |       | [ ]  |       |
| Reflux |       |       | [ ]  |       |
| Hiatus hernia |       |       | [ ]  |       |
| Gastritis |       |       | [ ]  |       |
| Gastric ulcer |       |       | [ ]  |       |
| Duodenal ulcer |       |       | [ ]  |       |
| H Pylori |       |       | [ ]  |       |
| Cancer in this area |       |       | [ ]  |       |
| Eating disorders |       |       | [ ]  |       |
| Food allergies/intolerances |       |       | [ ]  |       |
| Bloating and flatulence |       |       | [ ]  |       |
| Irritable bowel syndrome |       |       | [ ]  |       |
| Constipation |       |       | [ ]  |       |
| Diarrhoea/loose stools |       |       | [ ]  |       |
| Bleeding from the digestive tract |       |       | [ ]  |       |
| Appendicitis |       |       | [ ]  |       |
| Bowel polyps |       |       | [ ]  |       |
| Campylobacter |       |       | [ ]  |       |
| Coeliac |       |       | [ ]  |       |
| Colitis |       |       | [ ]  |       |
| Diverticulitis/diverticulosis |       |       | [ ]  |       |
| Haemorrhoids |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **RESPIRATORY SYSTEM**  | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Sinusitis  |       |       | [ ]  |       |
| Rhinitis |       |       | [ ]  |       |
| Catarrh  |       |       | [ ]  |       |
| Post nasal drip |       |       | [ ]  |       |
| Adenoids |       |       | [ ]  |       |
| Hay fever |       |       | [ ]  |       |
| Ear infections |       |       | [ ]  |       |
| Glue ear |       |       | [ ]  |       |
| Meniere’s |       |       | [ ]  |       |
| Tinnitus |       |       | [ ]  |       |
| Tonsillitis |       |       | [ ]  |       |
| Bronchitis |       |       | [ ]  |       |
| Asthma |       |       | [ ]  |       |
| Pleurisy |       |       | [ ]  |       |
| Pneumonia |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **URINARY SYSTEM** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Bladder prolapse |       |       | [ ]  |       |
| Cystitis  |       |       | [ ]  |       |
| Kidney stones |       |       | [ ]  |       |
| Nephritis |       |       | [ ]  |       |
| Nocturia (frequent urination at night) |       |       | [ ]  |       |
| Urinary incontinence/urgency |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **FEMALE REPRODUCTIVE SYSTEM** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Age at onset |       |  |  |  |
| Age at menopause |       |  |  |  |
| How many children did you have? | Number:      |  |  |  |
| Amenorrhoea (lack of periods) |       |       | [ ]  |       |
| Menorrhagia (very heavy periods) |       |       | [ ]  |       |
| Dysmenorrhoea (painful periods) |       |       | [ ]  |       |
| Endometriosis |       |       | [ ]  |       |
| PCOS |       |       | [ ]  |       |
| Fibroids |       |       | [ ]  |       |
| Infertility |       |       | [ ]  |       |
| Cervical dysplasia |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **MALE REPRODUCTIVE SYSTEM** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Enlarged prostate (BHP) |       |       | [ ]  |       |
| Prostatitis |       |       | [ ]  |       |
| Infertility |       |       | [ ]  |       |
| Testosterone deficiency |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **CIRCULATORY SYSTEM** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Palpitations |       |       | [ ]  |       |
| Tachycardia |       |       | [ ]  |       |
| Bradycardia |       |       | [ ]  |       |
| Atrial fibrillation |       |       | [ ]  |       |
| Ventricular fibrillation |       |       | [ ]  |       |
| High cholesterol |       |       | [ ]  |       |
| Hypertension |       |       | [ ]  |       |
| Hypotension (postural or other) |       |       | [ ]  |       |
| Vertigo |       |       | [ ]  |       |
| Fluid retention  |       |       | [ ]  |       |
| Stroke (including TIA) |       |       | [ ]  |       |
| Headaches  |       |       | [ ]  |       |
| Migraines |       |       | [ ]  |       |
| Anaemia  |       |       | [ ]  |       |
| Polycythaemia |       |       | [ ]  |       |
| Thrombosis: lungs/legs /other (name)  |       |       | [ ]  |       |
| Bruising (easy) |       |       | [ ]  |       |
| Aneurysm |       |       | [ ]  |       |
| Chilblains  |       |       | [ ]  |       |
| Phlebitis  |       |       | [ ]  |       |
| Raynaud’s |       |       | [ ]  |       |
| Varicose veins |       |       | [ ]  |       |
| Vasculitis |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **NERVOUS SYSTEM** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Bell’s Palsy |       |       | [ ]  |       |
| Epilepsy |       |       | [ ]  |       |
| Guillain Barré syndrome |       |       | [ ]  |       |
| Post-herpetic neuralgia |       |       | [ ]  |       |
| Shingles |       |       | [ ]  |       |
| HSV (herpes simplex virus) |       |       | [ ]  |       |
| Herpes zoster |       |       | [ ]  |       |
| Meningitis  |       |       | [ ]  |       |
| Neuralgia |       |       | [ ]  |       |
| Numbness/Pins and needles |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **PSYCHOLOGICAL NERVOUS** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Anxiety |       |       | [ ]  |       |
| PTSD |       |       | [ ]  |       |
| Panic disorders |       |       | [ ]  |       |
| Depression (SAD) |       |       | [ ]  |       |
| Bi-Polar disorder |       |       | [ ]  |       |
| Phobias (name) |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **EYES** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Cataract  |       |       | [ ]  |       |
| Dry eye syndrome |       |       | [ ]  |       |
| Glaucoma  |       |       | [ ]  |       |
| Macular degeneration |       |       | [ ]  |       |
| Iritis |       |       | [ ]  |       |
| Photophobia |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **MOUTH** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Gingivitis |       |       | [ ]  |       |
| Mouth ulcers |       |       | [ ]  |       |
| Dental problems (please specify) |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **SKIN** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Acne |       |       | [ ]  |       |
| Allergies (that affect skin) |       |       | [ ]  |       |
| Dermatitis |       |       | [ ]  |       |
| Eczema |       |       | [ ]  |       |
| Lichen Planus |       |       | [ ]  |       |
| Psoriasis |       |       | [ ]  |       |
| Warts |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **JOINTS & MUSCLES** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Arthritis (osteo) |       |       | [ ]  |       |
| Arthritis (rheumatoid) |       |       | [ ]  |       |
| Fibromyalgia |       |       | [ ]  |       |
| Gout  |       |       | [ ]  |       |
| Hernias (inguinal, umbilical) |       |       | [ ]  |       |
| Prolapse (state where) |       |       | [ ]  |       |
| Hypermobility |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **INFECTIOUS HISTORY** | Age | Duration | Select if current | Treatment (medication, alternative treatment, surgery) |
| Candida/tinea |       |       | [ ]  |       |
| Dengue fever |       |       | [ ]  |       |
| Glandular fever (Epstein Barr) |       |       | [ ]  |       |
| Lyme’s disease |       |       | [ ]  |       |
| Malaria |       |       | [ ]  |       |
| Rheumatic fever |       |       | [ ]  |       |
| Scarlet fever |       |       | [ ]  |       |
| Tuberculosis |       |       | [ ]  |       |
| Swollen lymph nodes (chronically swollen) |       |       | [ ]  |       |
| Candida |       |       | [ ]  |       |
| Other, please specify       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| **OTHER**If you have had any other health issues/diagnoses not mentioned in this section please can you say what these were, the age it was diagnosed, how long you had it and what the treatment was. |
|       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
|       |       |       | [ ]  |       |
| Please take this opportunity to add any other health information you feel may be useful or that you may be concerned about |
|       |
| **GENERAL DIETARY INFORMATION** |
| Diet can play a key role in getting you to where you would like to be health-wise, so it's useful to have a bird's eye view of your dietary choices and where you feel you may need the most help in improving your diet. |
| **Which foods do you omit from your diet and why?** |
|  | Allergy | intolerance | Prefer not to | Cultural/religious restrictions |
| Dairy | [ ]  | [ ]  | [ ]  | [ ]  |
| Wheat | [ ]  | [ ]  | [ ]  | [ ]  |
| Gluten | [ ]  | [ ]  | [ ]  | [ ]  |
| Grains | [ ]  | [ ]  | [ ]  | [ ]  |
| Meat | [ ]  | [ ]  | [ ]  | [ ]  |
| Chicken | [ ]  | [ ]  | [ ]  | [ ]  |
| Fish | [ ]  | [ ]  | [ ]  | [ ]  |
| Sugar | [ ]  | [ ]  | [ ]  | [ ]  |
| Salt | [ ]  | [ ]  | [ ]  | [ ]  |
| Processed foods | [ ]  | [ ]  | [ ]  | [ ]  |
| Other (specify) | [ ]  | [ ]  | [ ]  | [ ]  |
| If you think you could improve your diet, what would most help in making those improvements? |
|       |
| Signed: |       |
| Date: |       |