Thank you for your enquiry.

Welcome to the Health Commons Ready Reckoner Training.

The first step is to complete this Ready Reckoner Application so that we can prepare all your templates and help you get the ball rolling for your first training session. Once we have received this you will be ready to start the training.

There will be five training sessions in total, each lasting for an hour, where you will learn how to simplify your case, do some research, create a strategy and determine what you need. You will need to do some homework between each session and I ask that you allow from 1 – 2 hours to complete the homework using the templates provided, and to submit this prior to each session. Doing the homework is important as it is only through this that you will learn how to use the framework and become sufficiently skilled to take the reins of your case.

Training sessions 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 provide your name and full address on the form so that I can send your copy of the Ready Reckoner, Course Companion Guide, and your preferred method of payment.

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

Warm Regards

Kathryn Alexander

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| **PROFILE** |
| Current date |  |
| Name and Title |       |
| Sex (Male/Female) |       |
| e-mail address |       |
| Postal Address  | Street number/name       |
| City       |
| State       | Postal Code       |
| Country       |
| Contact telephone | Telephone       |
| Preferred method of payment | [ ]  Direct Debit (Australia only) | [ ]  Credit card (Visa or Mastercard only) |
| 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** |
| Can you let us know how much your general health (physical and mental) impacts your life on a scale of 1-10 where 1 = not at all impacting and 10 = 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*  |
| In what area of your life does most of your stress lie? |       |

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| **MY DIAGNOSES** |
| 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       |
| **SYMPTOMS** |
| Add your 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? |
|       |       |       |       |
| **Pelvis – genito/urinary***Please list your symptoms below* | What makes it worse? | What makes it better? | How long have you had it? |
|       |       |       |       |
| **Arms and legs***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? |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **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: |       |