Bloom Family Health

Fertility Form

Confidential Client Health Summary

Names Self & Partner: _____

DOB(Female): _____/_____/_____ DOB(Male): _____/_____/_____

Home Phone: _____ Mobile: _____ Email: _____

Address: _____

_____

Occupations (Male) Current: _____ Previous: _____

Occupations (Female) Current: _____ Previous: _____

Your GP: _____ Clinic: _____ Phone: _____

If applicable Your Gynae: _____ Clinic: _____ Phone: _____

Your Fertility Specialist: _____ Clinic: _____ Phone: _____

How did you find out about me? (please circle) Newspaper/Letter box/Internet/FB/Doctor/Friend/Other: _____

Have you seen or are seeing any other homeopaths, naturopaths, nutritionists etc. or natural health practitioners? _____

If so who: _____ For?_____

History – as applicable

How long have you been trying to conceive? _____Any pregnancies/miscarriages? _____

When? _____ What tests have been done (Male & female)? _____

_____

_____

Past IVF treatments? _____ When? _____

Outcome? _____

Current Medications and Natural Supplements (Male)

Name	Reason	Duration	Dosage

Current Medications and Natural Supplements (Female)

Name	Reason	Duration	Dosage

Continued over page...

Please indicate if you, your partner or family members has or has had any of the following conditions. For family history - Parents, siblings or grandparents use (Female) or (Male) to indicate which side this relates to.

	You	Your Partner	Other Family Members
Alcoholism			
Allergies, hay fever, sinusitis			
Anaemia, Blood clotting disorders			
Asthma, bronchitis, lung disease			
Cancer, Leukaemia			
Coeliac /Crohn disease/sensitivities			
Depression/mental health disorders/Anxiety			
Diabetes			
Headaches, Migraines			
Heart disease, hypertension			
Hemochromatosis, Jaundice			
Immune disorders, Colds/Flu/ lupus/ SLE			
Infectious disease (HIV, hepatitis etc)			
Lumps/cysts/tumours			
Obesity, oedema			
Viral infections- Ross river etc			
Sexually Transmitted Diseases			
Stroke, Neural disorders			
Thyroid disorders			
Varicose veins, thrombosis, Varicocele			
Arthritis			
Other			

The role of a natural therapist in your health is not to replace your medical doctor but where possible to work in conjunction with your medical practitioner, to bring about improvement in your overall health and well-being. In some cases, you might need to contact your doctor to get past health history, or to request blood tests or other investigations.

As part of your treatment I will need to contact you to see how you are responding. Please circle your preferred contact method and times:
MOBILE/HOME PHONE……. ANYTIME/MORNING/AFTERNOON

Confidentially: Any personal information you provide to this clinic, will be treated with strict confidentiality. This information will not be made available to any third party without your express written consent.

Disclaimer: It is important that you understand that I am a Naturopath, herbalist and homeopath, and not a Medical Doctor. As such, certain conditions, diseases or illness may require referral to a medical doctor for full diagnosis and treatment.

Appointments: Appointments are only conducted via phone, email, Skype, FaceTime or similar.

Appt type preference? _____

Preferred Days & Times_____

Payment: Fees for your initial consultation is $75.00, additional (follow up) appointments cost $50.00. All fees payable at or prior to appointment. Fees valid to 31st Dec 2020. If you prefer to pay by direct debit see below – Use Name on payment memo. Bloom Family Health – Bendigo Bank - 633-000 134934736.

Cancellation Policy:
Please Note: I have a strict cancellation policy, to enable all of my patients to have access to well-priced, quality care. As such, you will receive an appointment reminder 24 hours before your appointment. If you are not able to attend, you need to let me know as soon as possible so that I can offer it to someone else. Less than 12 hours notification and No Shows will be charged at FULL fee as I am not able to fill your appointment slot at short notice. Thank you for your understanding.

I have read the above information and I have answered the questions relating to my medical history to the best of my knowledge.

Client/s Name & Signature:

_____ _____

Date: _____