Pre-Consultation Questionnaire

Naturopathy with Olivia.

Welcome to Naturopathy with Olivia and congratulations on taking the first step towards improving your health and well-being the natural way.

Below you'll find a series of questions designed to help Olivia find out about you and your health history. Please complete and submit the questionnaire **at least 48 hours before your initial consultation** so Olivia has plenty of time to prepare for your appointment.

The PCQ should take you about 20-25min to complete and you can save it at any point to complete later.

* *Required Field*

Personal Details

First Name:

Surname:

DOB

Sex ◯ Female ◯ Male

Country of Birth:

What is your racial / ethnic background:

Email:

Primary Phone:

Other Phone:

Address Line 1:

Address Line 2:

Address Line 3:

Suburb / Town:

State: ACT

Postcode:

Country:

Height (cm)

Weight (kg)

How did you hear about Naturopathy with Olivia?

- [ ] Google
- [ ] Natural Therapies Pages
- [ ] The Pilates Centre Mosman
- [ ] Twitter
- [ ] Facebook
- [ ] Instagram
- [ ] Pinterest
- [ ] Referred by Health Professional
- [ ] Referred by Friend / Family Member
- [ ] Other

Who were you referred by?

Health Profile

Which other health practitioners do you usually visit or have visited recently?

- [ ] GP
- [ ] Specialist
- [ ] Psychologist / Counsellor
- [ ] Physiotherapist
- [ ] Exercise Physiologist
- [ ] Chiropractor
- [ ] Osteopath
- [ ] Occupational Therapist
- [ ] Nutritionist / Dietician
- [ ] None
- [ ] Other

Please provide the title, name and phone number of your primary health practitioner:

Do you have any recent pathology tests you would like to upload (e.g., blood, stool or allergy tests)?

- ◯ Yes
- ◯ No

Please upload all tests here:

Select File

What are the main health concerns you wish to discuss with Olivia?

Health Concern 1:

Symptoms:

Where do you feel / notice the symptoms?

When did the symptoms first begin and what were you doing at the time?

What makes the symptoms better or worse (please distinguish)?

Health Concern 2:

Symptoms:

Where do you feel / notice the symptoms?

When did the symptoms first begin and what were you doing at the time?

What makes the symptoms better or worse (please distinguish)?

Health Concern 3:

Symptoms:

Where do you feel / notice the symptoms?

When did the symptoms first begin and what were you doing at the time?

What makes the symptoms better or worse (please distinguish)?

Please list any medications you are currently taking. This should include any herbal or homoeopathic remedies, as well as nutritional supplements such as multivitamins, fish oil, etc.

Are you currently taking any medication?

- ◯ Yes
- ◯ No

Medication 1:

Brand:

Dosage:

Medication 2:

Brand:

Dosage:

Medication 3:

Brand:

Dosage:

Medication 4:

Brand:

Dosage:

Medication 5:

Brand:

Dosage:

Other Medications (including brand and dosage):

Health Profile (Continued)

Do you engage in physical activity / exercise?

- ◯ Yes
- ◯ No

How often per week?

- ◯ Once
- ◯ 2-3 Times
- ◯ 4-6 Times
- ◯ Every Day

What type of activities?

Do you smoke?

- ◯ Yes
- ◯ No

How often?

- ◯ Daily
- ◯ Weekly
- ◯ Less than weekly

How many packets do you usually smoke in a week?

Do you drink alcohol?

- ◯ Yes
- ◯ No

How often?

- ◯ Daily
- ◯ Weekly
- ◯ Less than weekly

How many standard drinks would you usually consume in a single session?

How much water do you consume per day on average (include only straight water, not tea, etc.)?

- ◯ 0-250mL
- ◯ 250-500mL
- ◯ 500-750mL
- ◯ 750mL-1.0L
- ◯ 1.0L-1.5L
- ◯ 1.5L-2.0L
- ◯ 2.0L+

Are you generally..

- ◯ Thirsty?
- ◯ Thirst-less?

How many caffeinated drinks do you usually consume per day (e.g., tea, coffee, energy drinks, etc.)?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5+

How many colds / flus do you usually suffer per year?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5+

How long does it usually take you to recover?

How many bowel movements do you have per day on average?

- ◯ Less than one per day
- ◯ 1
- ◯ 2
- ◯ 3+

Do you menstruate?

- ◯ Yes
- ◯ No

What is the length of your menstrual cycle (days)

Tell us about your usual energy levels (1 = I have very little energy; 10 = I feel vibrant and full of energy)

	1	2	3	4	5	6	7	8	9	10
What is your energy like day-to-day?	○	○	○	○	○	○	○	○	○	○

Health Profile (Continued)

Tell us about your appetite (1 = I rarely feel like eating; 10 = I'm always hungry!)

	1	2	3	4	5	6	7	8	9	10
What is your appetite like day-to-day?	○	○	○	○	○	○	○	○	○	○

Are you usually hungry for breakfast?
○ Yes
○ No

Do you ever experience binge eating or drinking?
○ Yes
○ No

Are there any foods you experience cravings for?
○ Yes
○ No

What are they?

Are there any foods you experience aversion to?
○ Yes
○ No

What are they?

Please let us know the food and drinks you consume in a typical day, being as specific as possible.

Breakfast

Morning Snack

Lunch

Afternoon Snack

Dinner

Dessert

Health History

Did you experience any major illnesses or operations up until you turned 18 years old

- ◯ Yes
- ◯ No

Childhood Illness / Operation 1:

Childhood Illness / Operation 2:

Childhood Illness / Operation 3:

Childhood Illness / Operation 4:

Childhood Illness / Operation 5:

Others:

Have you experienced any major illnesses or operations since you turned 18 years old

- ◯ Yes
- ◯ No

Illness / Operation 1:

Illness / Operation 2:

Illness / Operation 3:

Illness / Operation 4:

Illness / Operation 5:

Others:

Do you have (or have you ever suffered) any diagnosed or undiagnosed allergies / intolerances?

- ◯ Yes
- ◯ No

Allergy / Intolerance 1:

Allergy / Intolerance 2:

Allergy / Intolerance 3:

Allergy / Intolerance 4:

Allergy / Intolerance 5:

Others:

Please tell us about your family's health history below, indicating which (if any) of your family members have experienced each of the listed health conditions.

Cardiovascular Disease

- ☐ Mother
- ☐ Father
- ☐ Siblings
- ☐ Maternal G'mother
- ☐ Maternal G'father
- ☐ Paternal G'mother
- ☐ Paternal G'father
- ☐ No-one
- ☐ I'm not sure

Diabetes

- ☐ Mother
- ☐ Father
- ☐ Siblings
- ☐ Maternal G'mother
- ☐ Maternal G'father
- ☐ Paternal G'mother
- ☐ Paternal G'father
- ☐ No-one
- ☐ I'm not sure

Obesity

- ☐ Mother
- ☐ Father
- ☐ Siblings
- ☐ Maternal G'mother
- ☐ Maternal G'father
- ☐ Paternal G'mother
- ☐ Paternal G'father
- ☐ No-one
- ☐ I'm not sure

Auto-immune Disease

- ☐ Mother
- ☐ Father
- ☐ Siblings
- ☐ Maternal G'mother
- ☐ Maternal G'father
- ☐ Paternal G'mother
- ☐ Paternal G'father
- ☐ No-one
- ☐ I'm not sure

Depression

- ☐ Mother
- ☐ Father
- ☐ Siblings
- ☐ Maternal G'mother
- ☐ Maternal G'father
- ☐ Paternal G'mother
- ☐ Paternal G'father
- ☐ No-one
- ☐ I'm not sure

Fertility Issues

- ☐ Mother
- ☐ Father
- ☐ Siblings
- ☐ Maternal G'mother
- ☐ Maternal G'father
- ☐ Paternal G'mother
- ☐ Paternal G'father
- ☐ No-one
- ☐ I'm not sure

Cancer

- [ ] Mother
- [ ] Father
- [ ] Siblings
- [ ] Maternal G'mother
- [ ] Maternal G'father
- [ ] Paternal G'mother
- [ ] Paternal G'father
- [ ] No-one
- [ ] I'm not sure

If anyone in your family has had cancer, please tell us the type of cancer/s and which family member experienced each:

Have we missed anything? Please tell us about any other familial health issues:

General Health Assessment

This is the final section and is designed to give us an overall look at your health. Please tick the boxes for any condition that you either currently experience, or have experienced in the past.

Gastrointestinal Health

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Heartburn / Reflux	○	○	○
Nausea	○	○	○
Indigestion	○	○	○
Bloating	○	○	○
Vomiting	○	○	○
Burping	○	○	○
Bleeding Gums	○	○	○
Bad Breath	○	○	○
Excessive Flatulence	○	○	○

Bowel / Stool Health

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Constipation	○	○	○
Diarrhoea	○	○	○
Blood in Stool	○	○	○
Mucous in Stool	○	○	○
Pungent Smell	○	○	○
Anal Itching	○	○	○
Worms / Parasites	○	○	○
Laxative Use	○	○	○
Fissures	○	○	○

Cardiovascular System

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Angina	○	○	○
Palpitations	○	○	○
Varicose Veins	○	○	○
Swollen Ankles	○	○	○
High Blood Pressure	○	○	○
Low Blood Pressure	○	○	○
High Cholesterol	○	○	○
Poor Circulation	○	○	○
Cold Feet or Hands	○	○	○
Heart Attack	○	○	○
Heart Murmur	○	○	○

Respiratory System

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Dizziness / vertigo	○	○	○
Coughing	○	○	○
Wheezing	○	○	○
Shortness of Breath	○	○	○
Asthma	○	○	○
Nasal Congestion	○	○	○
Post Nasal Drip	○	○	○
Hay Fever	○	○	○
Sinus Congestion	○	○	○
Allergies	○	○	○

Musculoskeletal System

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Back Pain	○	○	○
Joint Pain / Stiffness	○	○	○
Osteoporosis	○	○	○
Osteoarthritis	○	○	○
Rheumatoid Arthritis	○	○	○
Neck Problems	○	○	○
Muscle Cramps	○	○	○

Endocrine System

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Excessive / Rapid Weight Gain	○	○	○
Excessive / Rapid Weight Loss	○	○	○
Blood Sugar Problems	○	○	○
Over-active Thyroid	○	○	○
Under-active Thyroid	○	○	○
Night Sweats	○	○	○

Nervous System

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Headaches	○	○	○
Migraines	○	○	○
Poor Concentration	○	○	○
Confusion	○	○	○
Poor Memory	○	○	○
Loss of Sensation	○	○	○
Poor Coordination	○	○	○
Pins and Needles	○	○	○
Tinnitus	○	○	○
Fatigue	○	○	○
Learning Difficulties	○	○	○
ADD / ADHD	○	○	○

Liver / Gall Bladder Health

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Issues Digesting Fats	○	○	○
Poor Alcohol Tolerance	○	○	○
Gall Bladder Removal	○	○	○
Hepatitis	○	○	○

Immune System

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Frequent Colds / Flus	○	○	○
Swollen Glands	○	○	○
Thrush or Candida	○	○	○
Cancer	○	○	○
HIV / AIDS	○	○	○
Glandular Fever	○	○	○
Auto-immune Condition	○	○	○

Urinary Tract Health

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Increased Thirst	○	○	○
Urinary Tract Infections	○	○	○
Issues Passing Urine	○	○	○
Kidney Pain	○	○	○
Decreased Flow	○	○	○
Increased Frequency	○	○	○
Passing Urine at Night	○	○	○
Leakage Caused by Loud / Sudden Noises	○	○	○

Finger and Toe Nail Health

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Soft	○	○	○
Splitting / Brittle	○	○	○
White Spots	○	○	○
Flaking	○	○	○

Energy Levels

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Energy Peaks	○	○	○
Energy Crashes	○	○	○

Skin Health

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Eczema / Dermatitis	○	○	○
Psoriasis	○	○	○
Warts	○	○	○
Dry Skin	○	○	○
Oily Skin	○	○	○
Acne	○	○	○
Poor Wound Healing	○	○	○
Excessive Sweating	○	○	○
Rash / Irritation	○	○	○
Offensive Body Odour	○	○	○

Haematology

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Anaemia	○	○	○
Haemochromatosis	○	○	○
Easy Bruising	○	○	○
Frequent Nosebleeds	○	○	○

Hair

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Increased Loss	○	○	○
Poor Quality / Breakage	○	○	○
Dandruff	○	○	○
Dry Hair	○	○	○
Oily Hair	○	○	○

Sleep

	I currently experience this	I've experienced this in the past	I've Never Experienced This
Trouble Falling Asleep	○	○	○
Trouble Staying Asleep	○	○	○
Nightmares	○	○	○
Vivid Dreams	○	○	○
Wake Tired	○	○	○
Bed-wetting	○	○	○
Snoring	○	○	○

Mental and Emotional Health

	I currently experience this	I've experienced this in the past	I've never experienced this
Mood Swings	○	○	○
Irritable	○	○	○
Prolonged Stress	○	○	○
Depression	○	○	○
Anxiety	○	○	○
Panic Attacks	○	○	○
Anger	○	○	○
Phobias	○	○	○

Female Reproductive System

	I currently experience this	I've experienced this in the past	I've never experienced this
Cysts or PCOS	◯	◯	◯
Endometriosis	◯	◯	◯
Fibroids	◯	◯	◯
STD	◯	◯	◯
Pap Smear Issues	◯	◯	◯
Breast Pain / Issues	◯	◯	◯
Infertility	◯	◯	◯
Pregnancy	◯	◯	◯

Menstrual Health

	I currently experience this	I've experienced this in the past	I've never experienced this
Irregular Cycle	◯	◯	◯
Heavy Flow	◯	◯	◯
Light Flow	◯	◯	◯
Clots	◯	◯	◯
PMS	◯	◯	◯
Menstrual Pain	◯	◯	◯
Ovulation Pain	◯	◯	◯
Spotting	◯	◯	◯

Have / are you experiencing menopause?

◯ Yes

◯ No

Menopause

	I currently experience this	I've experienced this in the past	I've never experienced this
Headaches / Migraines	○	○	○
Mood Changes	○	○	○
Hot Flushes	○	○	○
Night Sweats	○	○	○
Bone Problems	○	○	○
Panic Attacks	○	○	○
Anger	○	○	○
Phobias	○	○	○

Male Reproductive System

	I'm often exposed to this	I've been exposed to this in the past	I've never been exposed to this
Lymph Swelling	○	○	○
Balding	○	○	○
STD	○	○	○
Varicocele / Cysts	○	○	○
Hernia	○	○	○
Erectile Dysfunction	○	○	○
Impotence	○	○	○
Testicular Injury	○	○	○
Vasectomy	○	○	○
Infertility	○	○	○

Environmental Health Factors

	I'm often exposed to this	I've been exposed to this in the past	I've never been exposed to this
Microwave Usage	○	○	○
Computer Usage	○	○	○
Mobile Phone Usage	○	○	○
Living Near a Flight Path	○	○	○
Frequent Plane Travel	○	○	○
Chemical Usage	○	○	○
Multiple X-rays	○	○	○
Heavy Metal Exposure	○	○	○

Cancellation Policy

Programs cancelled at least 2 days prior to the initial consultation will receive a full refund of any monies paid to-date. The applicable date used for the initial consultation is the earliest date that has been agreed by both Naturopathy with Olivia and you, the client.

If you cancel anytime after this cut-off, up to and including the 28th day following your initial consultation, you'll be liable to pay the following percentage of the total non-discounted cost of each program:

- Introductory Natural Health Program - 100%
- Premium Natural Health Program - 65%
- Natural Fertility Program for Couples - 65%

Proportionate refunds will be given where full payment has been made up-front.

If you cancel anytime after the 28th day, up to and including the 56th day following your initial consultation, you'll be liable to pay the following percentage of the total non-discounted cost of each program:

- Premium Natural Health Program - 85%
- Natural Fertility Program for Couples - 85%

Proportionate refunds will be given where full payment has been made up-front.

Programs cancellations after the 56th day following your initial consultation will need to be paid for in-full.

If you can't make a consultation, we ask that you provide at least 48 hours' notice so that we can try to find an alternate time. We cannot guarantee that consultations cancelled within 48 hours of your scheduled appointment will be rescheduled.

I have read the above cancellation policy and agree to the terms ☐

Privacy Clearance and Consent

I understand that Olivia McFadyen (ATMS No. 26307) is a Naturopath, Nutritional Therapist, Herbalist and Homoeopath, and not a medical doctor. As such, any complementary health recommendations offered by Olivia McFadyen shall be taken in conjunction with any other treatment I may be receiving from my medical doctor.

I give my permission for any health history to be kept on file by Naturopathy with Olivia for the purpose of naturopathic treatment. I understand that all information within my file will be kept confidential at all times.

I give Olivia McFadyen permission to access past and current medical records from other health professionals or testing services as necessary. I also give Olivia McFadyen permission to release relevant details regarding my health to other health professionals when appropriate. I am aware that she will inform me if this occurs.

All information within this questionnaire has been provided to the best of my ability and is a true and accurate representation of my health.

In case of an emergency, please contact your general practitioner.

I have read, understand and agree to all that is contained within the Privacy Clearance and Consent Statement above. ☐ Date:

Keep in Touch

Tick this box to receive Olivia's regular newsletter ☐

Submit your PCQ