



Benjamin McAvoy

— The Healer Medium —

The Healer Medium
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Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____

Height: _____ Weight: _____

Name of GP: _____ Suburb: _____

Name of Specialist: _____ Suburb: _____

Specific reason for your appointment and other current health concerns:

1. _____

2. _____

3. _____

Recent pathology/tests/investigations/operations etc:

Have you experienced major stress in the last 12 months? (for example, death in the family, divorce, bankruptcy)

General Health Questionnaire:

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if you have never experienced this symptom.

<p><u>Gastro-intestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bloating <input type="checkbox"/> Flatulence <input type="checkbox"/> Reflux/Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Food intolerances 	<p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Persistent cough <input type="checkbox"/> Sneezing, wheezing <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Ear infections <input type="checkbox"/> Itchy eyes, ears, nose, throat <input type="checkbox"/> Sore throat 	<p><u>Skin</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Slow wound healing <input type="checkbox"/> Acne <input type="checkbox"/> Psoriasis <input type="checkbox"/> Dry, flaky skin <input type="checkbox"/> Oily skin <input type="checkbox"/> Eczema / skin rashes 	<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/> Palpitations <input type="checkbox"/> Dizziness <input type="checkbox"/> Varicose veins <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol
<p><u>Immune/Lymphatic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor immunity <input type="checkbox"/> Recurrent cold / flu <input type="checkbox"/> Hayfever / sinusitis <input type="checkbox"/> Fluid retention <input type="checkbox"/> Cold sores <input type="checkbox"/> Inflamed / bleeding gums <input type="checkbox"/> Auto-immune disease <input type="checkbox"/> Cancer 	<p><u>Sleep</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Insomnia <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Waking during night <input type="checkbox"/> Waking un-refreshed <input type="checkbox"/> Regular dreaming <input type="checkbox"/> Night sweats 	<p><u>Emotional</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> Poor memory <input type="checkbox"/> High stress levels <input type="checkbox"/> Feelings of being overwhelmed or unable to cope 	<p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Muscle aches or cramps <input type="checkbox"/> Joint pain <input type="checkbox"/> Restless legs <input type="checkbox"/> Muscle weakness
<p><u>Endocrine</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue / poor energy <input type="checkbox"/> Recent weight gain <input type="checkbox"/> Heat / cold intolerance <input type="checkbox"/> Hair falling out <input type="checkbox"/> Abdominal weight gain <input type="checkbox"/> Thyroid disorder 	<p><u>Urinary / Renal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain with urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Bloody, cloudy or smelly urine <input type="checkbox"/> Urinary tract infection 	<p><u>Male hormone balance</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Low libido <input type="checkbox"/> Difficulty starting urine flow <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Difficulty maintaining erection <input type="checkbox"/> Genital rash or irritation <input type="checkbox"/> Painful testicles 	<p><u>Female hormone balance</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hot flushes <input type="checkbox"/> Night sweats <input type="checkbox"/> Change in menstrual cycle <input type="checkbox"/> Dry hair, skin or vagina <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Infertility <input type="checkbox"/> Miscarriage
<p><u>Pre-menstrual symptoms (women only)</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Depressed or teary <input type="checkbox"/> Anxious or irritable <input type="checkbox"/> Feeling aggressive or angry <input type="checkbox"/> Breast tenderness <input type="checkbox"/> Food cravings <input type="checkbox"/> Fluid retention/bloating <input type="checkbox"/> Back pain <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Headaches or migraines 	<p><u>Menstrual symptoms (women only)</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Long intervals between cycles <input type="checkbox"/> Cycles longer than 32 days <input type="checkbox"/> Cycles shorter than 24 days <input type="checkbox"/> Heavy blood flow or flooding <input type="checkbox"/> Passing of blood clots <input type="checkbox"/> Very light blood flow <input type="checkbox"/> Spotting before or after bleed <input type="checkbox"/> Period pain 	<p><u>Sexual Health</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Thrush <input type="checkbox"/> Genital herpes <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Irregular pap smear <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Burning or itching pain on genitals 	<p><u>Lifestyle</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Smoker _____ / day <input type="checkbox"/> Passive smoker <input type="checkbox"/> Coffee _____ / day <input type="checkbox"/> Tea _____ / day <input type="checkbox"/> Alcohol _____ / week <input type="checkbox"/> Recreational drugs <input type="checkbox"/> Exercise ____ / week <input type="checkbox"/> Excessive plane travel <input type="checkbox"/> Radiation exposure <input type="checkbox"/> Pesticide / herbicide exposure <input type="checkbox"/> Bleach and ammonia use (cleaning) <input type="checkbox"/> High stress levels

Please list any health concerns of family members including siblings, parents and grandparents:

Current medications (including dosage):

Current supplements (dose and brand):

Current outlook of life.
