



## Kayla Booth

New Client Intake - Naturopathy

**Date of birth** 26 Mar 1988

**Practitioner** Leesa Young

**Appointment** 10 Aug 2023, 10:00AM

**Completed** 9 Aug 2023, 10:59AM

### Client Details

**Address** 46 glencoe road north arm

**Date of Birth** 26 Mar 1988

**Occupation** retail assistant

### Next of Kin

**Name** joe booth

**Relationship** husband

**Phone Number** 0400504918

### Referral Information

**Referred by**

- ☐ Family/friend
- ☒ Advertisement
- ☐ Walk/drive by
- ☐ Social media
- ☐ Practitioner
- ☐ Other

### Health History

**Have you seen a naturopath before?**

- ☒ Yes
- ☐ No

**What is your main presenting condition/concern today?** to see my hormones and overall health

**Do you have any children? If yes how many and ages** 4

Are you trying to conceive?

- ☐ Yes  
☒ No

Do you have any known allergies

no

Are you a smoker and/or vaper?

- ☐ Yes  
☒ No  
☐ Former

List any recent or previous surgeries or procedures you have had done

Any significant past or current medical diagnosis?

How frequently have you taken antibiotics

- ☐ Regular - more frequently than monthly  
☐ Monthly  
☐ 2-3 times per year  
☐ Once per year  
☒ Rarely

Are you on hormonal contraceptive?

- ☐ Yes  
☒ No  
☐ N/A

What have you used for contraception?  
(select all that apply)

- ☐ Oral contraceptive (the pill)  
☐ Mini pill (progesterone only)  
☐ IUD  
☐ Implanon  
☐ Surgical  
☐ Withdrawal  
☐ Temperature tracking  
☒ N/A  
☐ Other

Do you (or have you recently) suffer/ed from any of the following?

- ☒ Dizziness, vertigo, light headedness  
☒ High stress levels  
☒ Insomnia, Restless Legs  
☒ Anxiety and/or depression  
☐ ADHD (diagnosed or assumed)  
☒ Recurrent fatigue  
☐ Thrush, candida, recurrent UTIs  
☒ High blood pressure, poor circulation, high cholesterol  
☐ Other known heart conditions  
☒ Headaches, migraines  
☐ Regular sinus infections, allergies  
☒ Acne, psoriasis, eczema  
☒ Regular gut symptoms: bloating, gas, diarrhoea, constipation, heart burn, nausea  
☐ Viral infections (HSV, EBV, CMV, HPV or other)  
☐ Nerve pain (shingles, fibromyalgia etc)  
☐ Sore muscles or cramping  
☒ Tingling or numbness  
☒ Panic attacks  
☐ Difficulty breathing  
☐ Covid  
☐ Diabetes or Pre-diabetes  
☐ Endometriosis, adenomyosis,

- ☐ Amenorrhea, dysmenorrhea, irregular periods
- ☐ Infertility concerns, recurrent miscarriage
- ☐ Other musculoskeletal conditions

## Medication and Supplements

**What medication (including dose and frequency) are you currently taking?** none

**What supplements are you currently taking (including brand, dose and frequency)** iron tablets

**Are you interested in hearing about functional testing options?** yes

**Do you have a budget in mind for your treatment today?** no

**How motivated are you to make positive change and meet your health goals?**

- ☒ Very motivated - I'm all in!
- ☐ I want to change but I feel nervous/unsure of what to do
- ☐ I'm somewhat motivated, if it feels right for me
- ☐ I don't think I'm ready to change but I'd like to hear my options
- ☐ Not motivated

## Declaration

I, the undersigned understand that:

- The practitioner will ask a series of questions during the consultation to determine treatment plan suitability and likely causation of presenting complaints.
- I may choose to terminate the consultation at any time, but may be required to pay in full for the consult according the the Clinic Cancellation Policy.
- My health records are confidential and will be used for research and treatment purposes only. Under no circumstances will my file leave the server of The Well Collective Studio.
- It may be necessary from time to time for my case to be discussed with other health professionals (e.g. general practitioners, medical specialists, and/or complementary medical practitioners) and provide my consent for part/all of my medical case notes to be released for these purposes only.

On signing, I accept and agree to the Clinic Cancellation Policy and Clinic Refund and Return Policy.

**Signature**

