

## Return Visit Case Record - Naturopathy

Client #: Age: 19 Visit #: Last visit date: Date: 07/06/2023

Client name: Zoe Robertson

Supervisor name:

Student name: Tiana Quaife

Student #:

Risks update: Diagnosed medical conditions update

Allergies/Intolerance

s ☐

Pregnancy ☐

Lactation ☐

Medical Devices ☐

### Medications / Supplements Update

(Has the client stopped/started any new medication or supplements OR changed dosages?)

Drug Name & Class / Supp Brand & Name (including the OCP)	Dose (how much & how often)	Reason for Taking (condition, Prescribed by whom/self-prescribed)	Duration of TX (since when)	Result (effectiveness)

### Questions

Some time should have been spent devising a plan for the return visit. It is important NOT to ask the client to repeat information already provided. Look at the end of the most recent visit record for any planned follow up questions. Focus on questions that need to be asked to *extend* your understanding? What questions were missed in previous case taking? Remember to remain client-centred. LISTEN and be flexible in your approach.

### You may like to structure questioning or evaluation around the following:

#### 1. Ask the client questions to evaluate remedies/advice provided in the previous consultation:

- Were you able to implement any changes that were recommended?
- Did you have any problems taking the remedies or the required doses?
- How much is left in the herb bottle/tablets/powder?
- Have you noticed any changes to your condition or in general? (refer to original symptom picture)

#### 2. RE-EXAMINE TREATMENT AIMS

- Should there be changes to the original symptom picture by now? If so, what? And has this happened
- What specific outcomes (if any) have been achieved?
- Is the client heading in the right direction? Do they need more time or more information?
- Are the previous treatment aims still relevant?
- Does the client have any new symptoms/changes that need to be considered?
- Have their goals changed? Review short AND long-term goals.

\*Please note - if the client is returning to clinic after more than 6 months of absence, or is presenting with a different complaint or request for treatment, complete a New/Initial Case Record Form.

### Answers

(Use this area to record the client's response to your questions)

15mg carbinazole

Taking Iron (Maltofer - 1 x every second day), Vitamin D (Ostelin), C (Voost 1000mg),

Recent blood test - IgA short respiratory illness - 0.01% off being able to be diagnosed but after second test levels normalised

Sick monthly

Immune system - sore throat, runny nose, head cold

Got sick once - 1.5-2 weeks

Better within a week, faster than normal

Stress

Big stressful event at home a few weeks ago so believes will get sick

Sleep - study on the 16th

Bed at midnight, up at 7:40

Concentration

Been struggling a lot with concentration in school work

Started work and has been fine with that

Muscle aches and pains - walking more with work

Flower essences? ptsd, depression, anxiety - what else

LODCCTTRAP

(Review key points of original issue/complaint)

Issue/Symptom:	Update:

System/s Review

(Check systems that need questioning or review)

System:	Tick:	Notes:
CNS	<input type="checkbox"/>	
GIT	<input type="checkbox"/>	
ENT/Respiratory	<input type="checkbox"/>	
Immune	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	
MSK	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	
Reproductive	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	

Review Other

System:	Tick:	Notes:
Hair/Skin/Nails/ Oral Health	<input type="checkbox"/>	
Vitality/Energy	<input type="checkbox"/>	
Referral/Tests	<input type="checkbox"/>	

Diet

(Complete this section ONLY if this information was not obtained i the previous consultation OR if the client has made significant changes)

Main changes in diet since last visit?

24hr Recall / Typical Day's Diet

Breakfast:	( am)	
Snacks:	( am)	
Lunch:	( am/pm)	
Snacks:	( pm)	
Dinner:	( pm)	
Snacks:	( pm)	

Food Frequency (e.g. 3/7, 1/30 AND number of serves)

Animal (Meat, Fish, Eggs)	Dairy (Milk products, Butter/Spreads)	Soy (Soy products incl. soy proteins/isolates)	
Legumes	Fruit	Vegetables	
Nuts & Seeds	Grains/Cereals	Fats/Oils	Treats/Fast Food

Fluids:  
(Water/Coffee/Tea/Herbal Tea/Soft Drinks/Energy Drinks/Milk Drinks/Other Fluids/Alcohol)

Likes/Dislikes

Cravings

Eating Habits  
(e.g. chewing, eating on the run)

Vitality / Fresh vs Processed / Quality of Food / Raw vs Cooked / Thermogenics

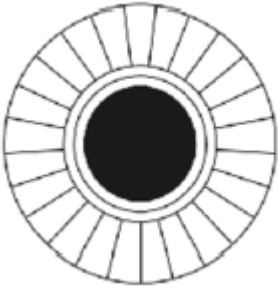
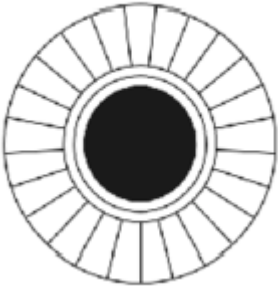
Person responsible for shopping & cooking / Home Prepares vs Take-away / Number of meals skipped per week

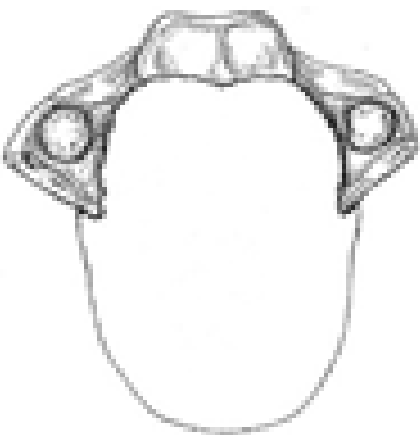
Macronutrient (excess / deficiency)	Micronutrient (excess / deficiency)	Phytonutrient (excess / deficiency)	

**Physical Examinations (Biomedical)**  
(Complete any relevant physical assessment needed for this consultation)

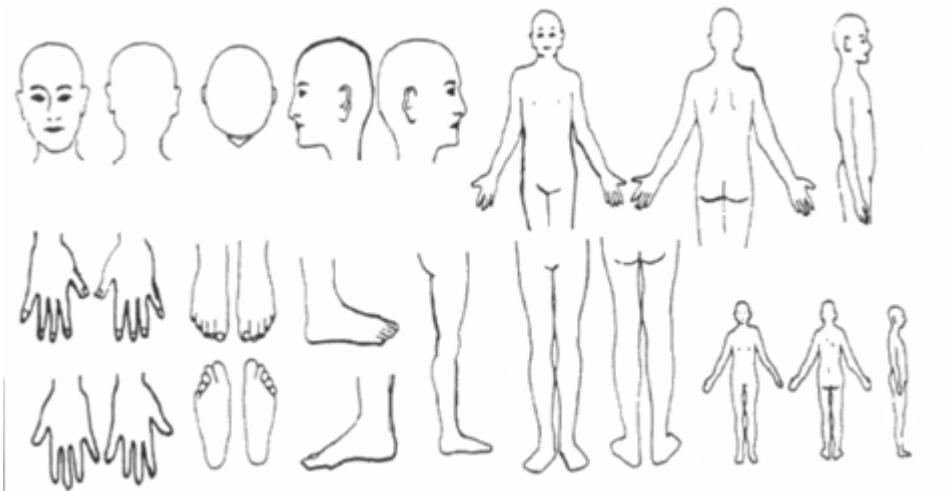
Blood Pressure (sitting)	Pulse	Temperature	Respiratory Rate
Blood Pressure (supine)	Circulation	Nerve Testing	Abdominal
Ears / Mouth / Throat / Glands	Skin (note where)		
Weight (kg)	Height (cm)	Waist (cm)	Hip (cm)
BMI (weight / height m³)		WHR	

**Physical Examinations (Holistic)**

Iris	Energetics
	
	
	Digestion
	Elimination
Nails Fingers/Toes	Tongue



Other



Further Examinations / Notes

Student  
Signature:

\_\_\_\_\_

Supervisor  
Signature:

\_\_\_\_\_