Bhuvaneswari Pranatharthihari

Herbal Whisperer

Personal Information

Mrs	Abirami
Dhurga	Muthupalaniappan
Abi	0406689303
Ph: Home	Ph: Work
abiramidhurga@gmail.com	19/10/1981
6 Emica Parade	
Knoxfield	Vic
Australia	3150
Teachers Aide	Male Female Other

Emergency contact

Ramanathan	Murugappan
0406689174	Husband

Referral source

How did you hear about this clinic?

Family or Friends

Health History

If you have a history of any of the following conditions, please select below.

- ☐ Heart disease
- ☐ Hypertension

- ☐ Hypotension
- ☐ Cholesterol
- ☐ Diabetes
- ☑ Asthma
- ☐ Severe weight loss/gain
- ☐ Gall stones
- ☐ Headaches
- ☐ Autoimmune condition
- ☐ Dizziness
- ☐ Severe fatigue
- ☐ Bruise easily
- ☐ Night sweats
- ☐ Skin conditions
- ☐ HIV
- ☐ Epilepsy
- ☐ Thyroid
- ☐ Mental health (other)
- ☐ Arthritis
- ☐ Cancer
- ☐ Post traumatic stress disorder (PTSD)
- ☐ Other health condition/s

Health history details

If you answered yes to any of the above questions, please provide further information here.

Asthma under control

Mental health (other) (briefly describe)

If you answered yes to any of the above questions under the section 'Health history' , please provide further information here.

Surgeries

Please list any surgeries you have had.

C-Section

Medicines/supplements

Please list any medications or supplements, including the dosage and the reasons you are taking them.

-

Alcohol consumption

How much alcohol do you consume on a weekly basis? -

Smoking

Do you smoke? When did you start and how often do you smoke? -

Excercise

What type of excercise do you do and how often? Yoga stretches on and off

List the name and dosage of all vitamins, minerals and natural supplements you are currently taking

-

Family Medical history (Family medical conditions)

Mother: Living/ Deceased List known medical conditions: Living - Arthritis

Father: Living/ Deceased List known medical conditions: Deceased - Heart Failure

Siblings: Living/Deceased List known medical conditions: Living

Mother's Mother: Living/Deceased List known medical conditions: Deceased

Mother’s Father: Living/Deceased List known medical conditions:	Deceased - Heart Failure
Father’s Mother: Living/Deceased List known medical conditions:	Deceased
Father’s Father: Living/Deceased List known medical conditions:	Deceased
Please list any other medical/health conditions or illnesses that are present in your immediate and extended family:	-

Current Complaint

What is the reason for your visit?	Perimenopause symptoms
When did the problem begin?	Early this year
What caused the problem?	Sudden bodily changes
What relieves your symptoms?	Rest
What aggravates your symptoms?	Multi-tasking
Have you consulted any other health professionals about this problem? If so, please provide details. below.	No

Pain scale

On a scale of 1-10 with 1 being minimal and 10 being maximum pain, how would you rate your pain?

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	◉	○	○	○

Mood scale

On a scale of 1-10 with 1 feeling very down and 10 feeling great, how would you rate your mood?

1	2	3	4	5	6	7	8	9	10
○	○	○	◉	○	○	○	○	○	○

Sleep quality scale

On a scale of 1-10 with 1 being very poor and 10 being excellent, how would you rate your sleep quality?

1	2	3	4	5	6	7	8	9	10
○	○	○	○	◉	○	○	○	○	○

Energy scale

On a scale of 1-10 with 1 being very low energy and 10 being very energetic, how would you rate your energy?

1	2	3	4	5	6	7	8	9	10
○	○	○	◉	○	○	○	○	○	○

Allergies/Intolerances

Dairy	○ Yes	◉ No
Soy	○ Yes	◉ No
Yeast	○ Yes	◉ No
Wheat	○ Yes	◉ No
Sulphites	○ Yes	◉ No
Gluten	◉ Yes	○ No
Peanuts	○ Yes	◉ No

Other nuts	○ Yes	◉ No
Sugars	○ Yes	◉ No
Cleaning products	◉ Yes	○ No
Tomatoes	○ Yes	◉ No
Artificial Flavours	◉ Yes	○ No
Artificial Colours	◉ Yes	○ No
Salicylates	○ Yes	◉ No
Shellfish/Fish	○ Yes	◉ No
Metals (Jewellery)	○ Yes	◉ No
Perfume/fragrance	○ Yes	◉ No
Alcohol	◉ Yes	○ No
Eggs	○ Yes	◉ No
Dust mites	◉ Yes	○ No
Medications	○ Yes	◉ No
Cigarette smoke	◉ Yes	○ No

Pollen	◉ Yes	○ No
Animal dander (fur)	◉ Yes	○ No
Other (Please mention)	○ Yes	◉ No

Other (Please mention)Animal dander (fur)PollenCigarette smokeMedicationsDust mitesEggsAlcohol Perfume/fragranceMetals (Jewellery)Shellfish/FishSalicylatesArtificial ColoursArtificial FlavoursTomatoes Cleaning productsSugarsOther nutsPeanutsGlutenSulphitesWheatYeastSoyDairy

Any other allergies (briefly describe)

Food recall diary

Breakfast

Bread and butter

Morning tea

-

Lunch

Rice with vegetables

Afternoon tea

-

Dinner

Rice and vegetables

Additional snacks

Potato chips

Liquids consumed

Tea and coffee on and off

Additional dietary notes

Experiencing bloatedness alot more recently

Have you had a covid-19 Vaccination?

Have you had a flu injection this year?

Have you donated blood recently?

Do you have a pacemaker or any implanted device?

What is your recent blood pressure reading?

Havent checked

Pregnancy and Lactation

Are you currently pregnant? ○ Yes ◉ No

Are you breastfeeding? ○ Yes ◉ No

List of test results

Private health fund details

If you have private health insurance that covers you for natural therapies, please provide your details below. Please note, not all practitioners and/or services are eligible for rebates.

Fund name (include the membership number and number on the card)

◉ Membership number

○ Number on the card

Treatment consent

I have to the best of my knowledge, provided all relevant information about my health and medical history and I give my full consent to treatment. I intend this consent to apply to all future treatments and I understand that I must update my service provider with any changesthat may occur in my medical history.

I consent for my practitioner to collect, store and utilize this personal information for the purposes of providing services to me in accordance with the relevant privacy legislation and any other legal requirements that may apply.

I understand that I need to provide a notice of cancellation of at least 2 days (48 hours) before the scheduled appointment, to be eligible for a refund of the session fee, minus a cancellation fee AUD20.00. Cancellations made one day (24 hours) before the scheduled appointment will not be eligible for a refund of the session fee.

☑ I consent to treatment

☐ I would like to receive communications on the latest news and offers

Client Name *

Abirami Dhurga Muthupalaniappan

Date

12/04/2025

☑ I am the client

☐ I am submitting on behalf of the client

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