RIFE CENTRE
CHRISTCHURCH

Confidential Health Questionnaire

Name: ……………………………………..….. Title: ………… Date of Birth: ..…/…../……..… Age: ….……

Address: …………..……………………………………………….. Marital/Relationship Status: …….…………….

………………………………………………………………………. No/Age of Children: …………………..……..

……………………………………………………………………….. Home Ph: ………………………………………..

City: ……………………………………… Postcode: …………... Work Ph: …………………………………………

Email: …….………………………………………….………………. Mobile Ph: …..……………………………………

Occupation: ………..

Doctor's Name: …………………………………………………….. Medical Centre: ……………………..............

Where did you hear about us: ……………………………………………………………………………………………

……….

Please ensure that your questionnaire details are in our hands at least 2 days PRIOR TO your scan appointment, otherwise the appointment will need to be rescheduled.

Please either use a computer (PC or MAC) to complete this form, or print it, fill it in by hand, save it, and return by mail or scan to email (this form does NOT work with iPads).

Mail it to Rife Centre
(ph 03 379 5200 for address)

or

email it to info@rife4life.co.nz

Name: ……………………………………………..

Blood Group: ……..   Usual BP: ………/………..

Please rate on a scale of 1 (low) to 10 (high)   Energy levels: …..…. Stress level: ……... Happiness: ………

Please describe the **MAIN HEALTH CONCERN** or symptoms that you are seeking help with:

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Please describe your main health goals for the next 12 months:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Please describe any important secondary symptoms or health concerns that you have (if any):

……………………………………………………………………………………………………

……………………………………………………………………………………………………

PRACTITIONER USE:

What is your usual BREAKFAST? ………………………………………………………………..

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What is your usual LUNCH? ……………………………………………………………………………………..

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What is your usual DINNER? ……………………………………………………………………………………

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How much WATER do you drink every day?   At least: ……. Glasses

What are your usual DRINKS? ….. cups of ………………………… ….. cups of ………………………………….

..….. glasses of ……………………………………………………………………………………………………

Which FATS / OILS do you use most? ……………………………………………………………………………

HOW MUCH: Margarine? ………………..   Soy? ……………..   Soft Drinks? ……………………………

Sweeteners? …………………………………   Sweets/Chocolate? ………………………………………………..

DENTAL - Any **ROOT CANALS**? ……………… How many **MERCURY FILLINGS**? ………………………………

SYMPTOMS CHECKLIST - To enable us to gain a complete view of your health, please tick ✓ if you have any of the following:

GENERAL
Headache / Migraines
Fever, Chills
Fainting
Dizziness
Loss of sleep
Nervousness
Weight loss / gain
Numbness/pain in arms /legs
Neuralgia
Change in thirst

EAR, NOSE, THROAT
Failing vision / Squint
Deafness
Earache / Ear noises
Ear discharges
Nose bleeds
Nasal obstruction
Sore throat / hoarseness
Asthma
Gum trouble
Enlarged thyroid
Tonsillitis
Sinus infection
Enlarged glands

SKIN
Skin eruptions
Itching
Bruise easily
Dry ness
Boils / Acne
Varicose veins
Sensitive skin
Shingles

RESPIRATORY
Chronic cough
Dry chesty cough
Productive cough
Spitting up phlegm
Spitting up blood
Chest pain

CARDIOVASCULAR
Irregular heartbeat
Blood Pressure High / Low
Pain over heart
Previous heart attack
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke
Blood clots

MUSCULOSKELETAL
Stiff neck
Backache - where ?
Jaw problems
Sciatica
Painful / Swollen joints - if so which ?

GENITOURINARY
Frequent urination
Painful urination
Urine discoloration
Kidney infection or stones
Bed wetting
Inability to control urine
Prostate concerns

GASTROINTESTINAL
Poor appetite
Excessive hunger
Indigestion
Belching/ flatulence
Nausea / Vomiting
Heartburn
Pain over stomach
Abdomen distension
Constipation
Diarrhoea
Haemorrhoid (piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice

WOMEN ONLY
Painful menstrual problems
Excessive flow
Hot flushes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Congested breast
Lumps in breast
Menopausal problems
PMS

PRACTITIONER USE:

DIAGNOSED DISEASES - If you have ever been diagnosed with any of the following diseases, please tick: ✓

Appendicitis
Pneumonia
Rheumatic fever
Pleurisy
Tuberculosis
Alcoholism??
Arthritis
Venereal disease
Epilepsy

Mental disorder
Gastric ulcers
Anaemia
Hepatitis
Herpes
Diabetes
AIDS
Thyroid
Cancer

Heart disease
Glandular fever
Thrush
Cystitis
Meningitis
Malaria
Depression
Irritable Bowel

MEDICAL PROCEDURES: Major Surgery? ………………………………… Broken Bones? …………………………

MEDICAL TESTS - Please give results of any investigations, eg X-Rays, mammograms, tests in last 5 yrs

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PRESCRIPTION DRUGS - Have you used any of the following – please indicate frequency and duration

Antibiotics Steroids Contraceptive Pills Sleeping Pills Antidepressants

Others / More Information: ……………………………………………………………………………………………

ALLERGIES AND SENSITIVITIES - Describe any allergies or food reactions that you experience.

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FAMILY HISTORY - Please note major diseases or causes of death for parents, grandparents or siblings.

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LIFESTYLE & HABITS

What **exercise** do you get and what form? ……………………………………………………………………………..

What **alcohol** do you drink and how often? …………………………………………………..............................

Do you **smoke** /how much / since when? ………………………………………………………………………………

Do you use any **recreational drugs** / how often? ………………………………………………………………………..

Hours of **sleep** per night? ………………… Frequency of **bowel movements**? …………………………. per day

Are you Vegetarian? ….. Vegan? ….. What proportion of your diet is uncooked/unprocessed? …………………..

Do you have any food cravings? …………………………………………………………………………………………

SUPPLEMENTS AND HERBS – Please list any food supplements or herbs that you take regularly.

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OTHER INFORMATION – Please note anything else you think is important not covered elsewhere.

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TERMS OF CONSULTATION – IMPORTANT:

All information provided by the Rife Centre Christchurch Ltd is for educational purposes only and is NOT intended as a substitute for professional medical advice, diagnosis or treatment.

I acknowledge that the staff of the Rife Centre Christchurch have explained to me that they are not medical practitioners and that they have no formal or informal qualifications in this area.

I accept responsibility for contacting my GP or specialist about any health concerns I may have. I will advise my GP or specialist about any treatment protocol I am following.

Signature of Client: …………………………………........ Date: ……/………/………