REACTIONS/ALLERGIES

Please list any/all past reactions, intolerances or allergies if known

Approx. Date/Year	Substance (if known) e.g. food	Reaction

DIET

Restrictions (if any)	Inclusions (if any)

Do you smoke? Yes ☐ No ☐ Substance ☐ Amount per day ☐

Do you consume alcohol? Yes ☐ No ☐ Amount per day/week ☐

AUTOIMMUNE PATIENTS ONLY

Previously diagnosed autoimmune conditions

Date	Disorder	Treatment

Previous relevant surgical procedures

Date	Procedure

Previous medical specialists seen

Date	Name	Reason	Outcome

Previous medications

Date	Medication	Reason administered	Outcome

Previous tests (please bring with you or have sent to us prior)

Date	Test	Reason/Result

Ongoing Chronic Symptoms

Date commenced	Symptom	Severity (interference with daily functioning 1-10). Where 1 is functioning ok, 10 is not functioning at all)

What are your current top 3 concerns:

1.

2.

3.

What, if anything, do you believe may have triggered your disorder/symptoms?

What outcome do you hope for from your consultation today?

Thank you for taking the time to complete this form. The information you provide assists us in providing you with quality healthcare.