Belmont Park Retreat Clinic of Natural Medicine

Informed Consent

You have consented to have a medical herbal consultation with Alicia Melrose, member of the NZAMH (NZ Association of Medical Herbalists).

Natural medicines are a natural form of health care treatment, which believes in the healing power of nature and stimulates the individual's inherent self-healing processes. As a medical herbalist, my aim is to empower you to improve your overall health, well-being by providing you with dietary and lifestyle advice, and if needed with safe and effective remedies. I will try to find the underlying cause of a condition and treat the entire individual person, by taking into consideration your emotions, physical body, diet, genetics, environment, spirituality and lifestyle.

Herbal medicines and supplements can be used effectively alongside conventional medical treatment, but should not replace it. However, it is important to inform your doctor as well as myself about any medications and supplements you are taking to avoid potential interactions. I cooperate with all branches of medical science, including conventional medicine. Patients may be referred to other health practitioners or a GP for diagnosis or treatment when appropriate.

What will the consultation involve?

During your initial consultation, you will be asked many questions about health issues. If you think of any information, no matter how unusual or insignificant it may seem to you, please tell me, as all these factors help to build the entire picture of you as a unique individual. The questions may not necessarily focus on the physical complaints that you have come for, but will aim to give me a much broader picture. Your initial consultation will take 1 ½ hours. Follow-up consultations are usually 60 minutes. I assure you, that the information you give me, will be kept strictly confidential.

During your session I may use one or more of the following modalities with your consent.

Nutritional advice	Kinesiology	Iridology/tongue diagnosis
Detoxification methods	Flower essences	Stress management
Healthy lifestyle and exercise	Aromatherapy	Homeopathy
Herbal medicine	Urine analysis	Nutritional supplements

Do you understand what is involved in this session or would you like me to explain further?

I, ____________________(clients' name), having read and understood the above information and have had all my questions answered to my satisfaction, consent to the consultations as explained to me by Alicia Melrose. If I wish I can receive a copy of this information for my own records.

Date: ________ Signature of Customer: _________________ Signature of Practitioner: _________________

Health Questionnaire

Name: ………………………………………… Email:…………………………………………

Address:……………………………………………………………………………………………

……………………………………………………………………………………………

Contact No.: ………………………… Fax: …………………………………

Sex: M F Date of Birth: ………………………

Age: ……… No. of Children (if any): ………

Occupation:……………… ………… Previous occupation:………………………

Relationship Status: Married/Living with partner Divorced/Separated Single

Hobbies:

…………………………………………………………………………………………………

Medical history:

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

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

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

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

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

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

Menstrual and obstetric history (age periods began, normal, abnormal, pregnancies, birth weight and problems):

……………………………………………………………………………………………………\

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

Present symptoms (see list on following page and use if required):

……

……

……

……

……

……

……

……

SYMPTOMS LIST

Please tick any symptoms that apply to yourself

PHYSICAL

General:

Excessive tiredness

Weight gain

Weight loss

Cold extremities

Cold sweats

Night sweats

Slow movements

Slow speech

Pins & needles

Breathlessness

Dizziness

Palpitations

Sensitivity to sun

Lack of co-ordination especially of hands and feet

Trembling

Insomnia

Loss of libido

Repeated urinary tract infections

Upper respiratory tract infections

Pelvic Inflammatory Disease (PID)

Poor response to treatments

Candida

Heavy eyelids

Hoarse voice

Goitre

Muscle cramps

Joint stiffness

Heat/Cold intolerance

Low basal temperature

Exercise intolerance

Salt craving

Sweet craving

Hypoglycaemia

Fainting attacks

Asthma

Internal shivering

Puffiness of:

Eyes

Face

Hands

Feet

Ankles

Mouth & Throat:

Difficulty swallowing

Sore throats

Swollen tongue

Choking fits

Dry mouth

Halitosis (bad breath)

Hearing Problems:

Oversensitive hearing

Noises in ears (hissing)

Deafness

Hair:

Body hair loss

Head hair loss

Brittle hair

Eyebrow loss (outer third)

Eyelash loss

Nails:

Brittleness

Flaking

Skin:

Dry

Flaky

Coarse patches

Sallow in colour

Pallor

Dark rings under eyes

Pigmentation in skin creases

Rashes & dermographia (wheals)

Numbness & Tingling in:

Legs

Feet

Arms

Hands

Back

Face

Pain:

Migraines

Pressure headaches

Back and loin pain

Wrist pain

Muscle and joint pain

Carpal Tunnel Syndrome

Digestive Problems:

Loss of appetite

Food allergy/sensitivity

Alcohol intolerance

Constipation

Haemorrhoids

Irritable Bowel Syndrome (IBS)

Abdominal distension/flatulence

Blood Pressure & Pulse:

High blood pressure

Low blood pressure

Slow/weak pulse (under 60 bpm)

Fast pulse (over 90 bpm at rest)

Menstrual disorders:

Cessation of periods (amenorrhoea)

Scanty periods (oligomenorrhoea)

Heavy periods (menorrhagia)

Infertility

PMS (premenstrual tension)

Visual disturbances:

Poor focusing

Double vision

Dry eyes

Gritty eyes

Blurred vision

MENTAL

Panic attacks

Memory loss & confusion

Mental sluggishness

Poor concentration

Noises and voices in head

Hallucinations

Phobias

Loss of drive

Post Natal Depression

Nightmares

EMOTIONAL

Easily upset

Wanting to be solitary

Mood swings

Depression

Nervousness/anxiety

Personality changes

Feelings of resentment

Lack of confidence

ANY OTHER SYMPTOMS

Blood test history: (Please complete as far as you can. Any results should include reference range.)

Please attach copies of any laboratory tests you have.

Please attach copies of any other laboratory test results, for example, hair analysis, stool analysis etc.

TEST Date Result Reference Range

Do you have any yeast or Candida infections, e.g., athlete's foot, skin rashes, nail infections?

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

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

Please give an example of your daily diet:

Breakfast:……………………………………………………………………………………………

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

Lunch:………………………………………………………………………………………………

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

Dinner:
………………………………………………………………………………………………………

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

Snacks:
………………………………………………………………………………………………………

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

Drinks (including alcohol):
………………………………………………………………………………………………………

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

Vitamin and mineral supplementation:..…………………………………………………… …………

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

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

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

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

Do you have any food cravings? (please specify)

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

Which foods do you hate and therefore avoid eating? (NOT due to allergy or intolerance)

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

Which particular food and drink do you consume the most of every single day?

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

Are you aware of any food allergies or intolerances?

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

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

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

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

Do you have any intolerances to medication?

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

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

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

Is there a family history of confirmed diagnosis of: (please tick and specify which relation, e.g. mother, paternal aunt, maternal grandfather, maternal cousin)

Thyroid disease ………………………………… ME/CFS ………………………………….

Fibromyalgia …………………………… Autoimmune disease ……………………………

Diabetes ……………………………………… Arthritis ……………………………………

Heart disease/Stroke …………………………… Mental illness ……………………………

Other (please specify): ……………………………………………………………………….

Any comments about family history:
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………

Have you been diagnosed with:

Thyroid disease ME/CFS Fibromyalgia Autoimmune disease

Diabetes Heart disease/Stroke Mental illness Arthritis Other

Please specify: (eg Hashimoto’s, Hypothyroidism, Lyme’s Disease)
……………………………………………………………………………………………………
……………………………………………………………………………………………………

Date medical advice first sought: (approx)……… …………………… Age:………

Date diagnosed: (approx)……………………………………………… Age:………

Date symptoms began: (approx)…………………………...……… Age:………

Was private advice sought: Yes No

Reasons/Details:
……
……
……

Personal history of other illnesses before diagnosis: (please give ages where possible)

Glandular fever   Severe viral infection (eg Flu)   Diabetes

Any other illnesses:
……
……
……

Details/Comments

……
……
……
……

Did you experience any major life events before diagnosis - mental or physical trauma, surgery etc:

(please give ages where possible)

Hysterectomy   Neck injury/Whiplash   Tonsillectomy   Cholecystectomy

Traumatic pregnancy/Birth   Severe accident   Divorce   Bereavement

Any other events:…...……………… ………………………………………………………….……………....
………………….……………………………………………………………………………………..
……

Details/Comments

……

……

……

……

Have you ever lived in a fluoridated water supply area: Yes No

Dates: (approx)
...……………………………………………………………………………………….…………

Have you had exposure to other environmental hazards: Yes No

Dates/Details:
……………………………………………………………………………………………..…

……

……

……

Have you experienced long-term exposure to electromagnetic fields (living near power lines, working with electrical machinery etc): Yes No

Dates/Details:
……………………………………………………………………………………………..…

……

……

……

If you have been diagnosed with thyroid disease and/or low adrenal reserve, or been given a trial treatment of thyroid hormone and/or adrenal support:

Date first diagnosed: (approx)…………………………… Age:………………

Past average basal temperature (if any): …………………………………………………………………

Past average basal pulse rate (if any): ……………………………………………………………………

Now give a history of your treatment to include the medication and the dosages.

………

………

………

………

………

………

………

………

………

………

………

Now give your present treatment, including supplements.

………

………

………

………

………

………

………

………

………

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

As the following readings are important as an indication of your present metabolic status, would you please ensure you do them. Please take your basal temperature in the morning – immediately on waking and before getting out of bed – 3 minutes in the mouth. Ladies only do this during your period. Pulse rate – bpm – number of beats per minute.

Present average basal temperature: (eg 36.5 C)

Day 1 ………... Day 2 ……….... Day 3 ……….... Day 4 ……….... Day 5 ……….…

Present average basal pulse rate: (eg 72 bpm)

Day 1 ………... Day 2 ……….... Day 3 ……….... Day 4 ……….... Day 5 …………

Any other comments about your past or present treatment or health:

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

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

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

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

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

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

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

Please bring the completed form with you to your first appointment or mail it to

Our Address:
Belmont Park Retreat Clinic of Natural
147 Stratton Street, Normandale, Lower Hutt

Phone: 04 586 0110

Email: **belmontparkretreat@gmail.com**

Website: **www.belmontparkretreat.co.nz**