NeuroBalance CHIROPRACTIC

Suite 29, 117 Old Pittwater Rd Brookvale, NSW 2100
P 02 9938 5456
E info@neurobalancechiropractic.com.au

Fertility Consultation Questionnaire

date ____

address ____ suburb ________________________ post

Partner 1 Name: __________________________________ **Partner 2** Name: ____________________________________

Mobile: ___________________ Work Ph: _____________ Mobile: ___________________ Work Ph: _____________

Email: ____ Email: ____

Date of Birth:______________ Blood Group: _____ Date of Birth:______________ Blood Group: _____

Occupation:__________________________________ Occupation:__________________________________

Any previous conceptions?: ☐ yes ☐ no Any previous conceptions?: ☐ yes ☐ no

If yes, details:________________________________ If yes, details:________________________________

Where did you hear about NeuroBalance Chiropractic?

☐ Google ☐ Yahoo ☐ msn ☐ friend

☐ Yellow Pages Online ☐ NT Pages ☐ True Local ☐ other __________________

Would you like to receive NeuroBalance Chiropractic communication e.g health newsletters & clinic updates? **please tick** ☐
(You will be able to unsubscribe at any time)

Are you currently seeing a GP, fertility specialists, other practitioner? If so, who?

____

Please list any current health or medical issues (e.g diabetes, arthritis, IBS etc):

Female: ____

Male: ____

Please list any medications you are currently taking or have previously taken for an extended period of time:

Female: ____

Male: ____

Please list any previous surgeries, hospitalisations, traumas (emotional or physical):

Female: ____

Male: ____

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When did you start trying to conceive? ____

Have you undergone any IVF cycles? Y / N If so, please provide details of when, what type of IVF and results

____

____

____

____

____

Do you currently take fertility drugs? Y / N ____ _

Do you have further treatments planned? Y / N ____

PLEASE NOTE: In addition to the information below, it is advised that you either *bring or email through any previous or recent medical test results*. You may need to request them from your GP or Specialist.

Reproductive health

Female - Reproductive health

Have you recently been on contraception? (e.g the pill, and IUD, ring etc) Y / N ___________________________________

Did you suffer any side-effects on the pill or IUD? Y / N ____

Have you ever had a cervical erosion/cone biopsy/laser treatment/cauterisation? Y / N ___________________________

Have you ever had any of the following?

- ☐ Endometriosis
- ☐ Pelvic inflammatory disease
- ☐ Ovarian cysts
- ☐ Candida (thrush)
- ☐ Herpes/blisters/warts
- ☐ Other STD_________________________
- ☐ Genitourinary infection
- ☐ fibroids
- ☐ Polycystic Ovarian Syndrome (PCOS)

Have you undergone any of the following medical investigations?

- ☐ Thyroid function tests
- ☐ Laproscopy
- ☐ Hysterosalpingogram
- ☐ Hysteroscopy
- ☐ Pelvic ultrasound
- ☐ Other ____________________________

____

____

____

Cycle

Average length of cycle is ______________days [shortest ________days longest ________ days]

How many days is your bleed? __________ On your heaviest day, how often do you change a tampon or pad? ______________

Do you experience any of the following with your period ?

- [ ] Dark blood (brown/black)
- [ ] Clotting
- [ ] Spotting before period starts
- [ ] Mid cycle spotting
- [ ] Mid cycle pain
- [ ] Severe cramping/pain

Do you suffer any of the following PMS symptoms ?

- [ ] Nausea/vomitting
- [ ] Sore/lumpy breasts
- [ ] Headaches
- [ ] Constipation/diarrhoea
- [ ] Skin problems
- [ ] Pain before period starts
- [ ] Food cravings
- [ ] Irritability
- [ ] Depression

Any recent changes to your cycle? ____

Charting

Have you ever charted your basal body temperature or cervical mucous changes? Y / N

If so, what changes have you observed____

____

Male

Have you received any treatment for reproductive or urinary problems? (including STD's, other infections, cancer) Y / N ______

____

Have you ever had semen analysis? (If recent, please provide a copy, you can request this from your doctor)

____

Have you ever, or do you have any of the following? Please tick.

- [ ] Testicular disease or injury
- [ ] Undescended testes as a child
- [ ] Vasectomy _________________________
- [ ] Mumps
- [ ] Herpes/blisters/warts
- [ ] Other STD_________________________
- [ ] Genitourinary infection
- [ ] Prostatitis
- [ ] Benign prostate hypertrophy
- [ ] varicoceles
- [ ] Low libido / impotence/ premature ejaculation
- [ ] Loss of body hair

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General health questionnaire

0= Never 1=Sometimes 2=Regularly (more than twice weekly) 3=Daily basis

Female				
Bloating or gasiness after meals	0	1	2	3
Have a burning feeling in stomach/heartburn	0	1	2	3
Have less than one bowel movement daily	0	1	2	3
Suffer diarrhoea	0	1	2	3
Abdominal cramps and pain	0	1	2	3
Haemorrhoids or rectal pain and bleeding after bowel motion	0	1	2	3
Chronic fungal infections of skin or nails	No	Yes		
More than 3 colds per year	No	Yes		
Often have a sore throat or swollen glands	No	Yes		
Suffer allergies	No	Yes		
Suffer asthma, eczema or arthritis	No	Yes		
Fatty foods cause indigestion	0	1	2	3
Suffer headaches/migraine	0	1	2	3
Sinus problems or stuffy nose	0	1	2	3
Excessive mucus or post nasal drip	0	1	2	3
Chronic cough or asthma	0	1	2	3
Strong body odour	0	1	2	3
Muscle or joint aches and pains	0	1	2	3
Broken sleep/insomnia	0	1	2	3
Feel tired or overworked	0	1	2	3
Need coffee, tea, sugar or tobacco to give you energy	0	1	2	3
Have noticeable energy slumps during the day	0	1	2	3
Get dizzy, shake or become irritable if you skip a meal	0	1	2	3
Suffer mental confusion or have difficulty concentrating	0	1	2	3
Crave pasta, bread, sugar	0	1	2	3
Feel stressed, nervous or anxious	0	1	2	3
Suffer depression	0	1	2	3
Become easily anxious	0	1	2	3
Feel exhausted	0	1	2	3
Mood swings	0	1	2	3

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Male

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Have a burning feeling in stomach/heartburn	0	1	2	3
Have less than one bowel movement daily	0	1	2	3
Suffer diarrhoea	0	1	2	3
Abdominal cramps and pain	0	1	2	3
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Lifestyle/environment

Please tick ☑ if your answer is yes	Male	Female
Are you in regular contact with glues, plastics or paints?	☐	☐
Do you drive a recently new car?	☐	☐
Do you use hair dye?	☐	☐
Do you regularly use chemical cleaning/laundry products?	☐	☐
Do you use standard skincare, makeup and soaps? (not 100% natural)?	☐	☐
Have you recently renovated?	☐	☐
Do you have amalgam fillings in any of your teeth?	☐	☐
Do you use uncoated aluminium cookware?	☐	☐
Have you had any x-rays in the past 2 years?	☐	☐
Have you taken more than 1 flight per 6mnths?	☐	☐
Do you use your mobile phone regularly throughout each day?	☐	☐
How many hours do you use a computer per day?	_______hrs	_______hrs
Do you live or work near mobile phone/electricity towers or relay stations?	☐	☐
Do you eat fast foods such as KFC, McDonalds, Hungry Jacks?	☐	☐
Do you live on a main road?	☐	☐
Do you drink tap water?	☐	☐
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you ever take recreational drugs?	☐	☐
Do you drink unfiltered tap water?	☐	☐
Do you eat organic foods?	☐	☐

CBD Natural Health will not divulge to any person any confidential information concerning; patient personal, health and financial information; except as required by law.

Our Cancellation Policy
In order to serve others, we ask that you offer a courtesy call if you cannot keep your allotted appointment time. A 24 hour notice is required for cancellation of appointments without acquiring a "no-show" charge of your full consultation fee. Please be considerate.

Scheduled appointments are set up in order to accomplish getting you well. If you cancel your appointment, it may delay your recovery. If you must miss it, it is best to reschedule as so