TAMAR SKIN CLINIC
skin cancer
skin rejuvenation
skin health

Integrated Dermatology

# Wellness Health Questionnaire

**Please take the time to fill out this questionnaire. Your responses will help provide a valuable insight into the key areas and patterns in your life. Your answers will be held confidentially by Dr Alison Timms.**

## CONTACT INFORMATION

Full name: ……

Residential address: …… Postcode:……

Email: ……

Ph: (M) …… (W)……..(H)……

Date of birth: …… / …… / …… Age: …… Gender: ……

## SOCIAL HISTORY

Relationship status: (single/married/live with partner or separate / same sex) ……

Any comments or feelings about your relationship / status? This can be a main contributor to your health & wellbeing.

……

Do you have children? (ages/sex/any problems) ……

……

Do you have any pets? Please list: ……

Who is at home with you? ……

List any problems with current relationships? ……

Occupation (give description of what you do) ……

Studies (are you studying anything at present/ part of a course or self-study? List any courses/degrees/diplomas/certificates)

……

Hobbies/ things you enjoy doing. ……

Financial: Do you have any financial stress that may be impacting your health in some way? ……

……

## WELLBEING INFORMATION

What is your main problem about your wellbeing at present? ……

……

How long have these problems or concerns been affecting you? ……

……

And to what extent do they affect your work/sleep/exercise/meals/relationships? ……

……

Have you been prescribed any medications for your concerns or problem? ……

If so, please list. Are you still taking them?……

……

……

Current vitamin supplements, over the counter medications? (Please list dosages & brand)

……

What other therapies have you tried? e.g., acupuncture/osteopath/neuropathology etc. ……

……

Please describe any positive or negative responses: ……

Have you had any tests? e.g., bloods scan. Please list any known results……

……

Are you worried/concerned about any of the results? ……

List any concerns about testing that has or has not happened:……

List any past medical problems. Please include any problems that have involved chemotherapy, radiation, long courses of antibiotics and/or steroids. ……

……

**CHILDHOOD**

Please give any known details of your birth history e.g., were you a premature baby, delivered by caesarean/ any known physical trauma. Do you know if your mum or dad had a drug problem while you were in utero?
Have you had any significant childhood emotional or physical trauma? If so, give some details:

……

……

Briefly describe your childhood. Did you feel unwanted, loved, cared for? Or was it a survival experience?

……

……

During your childhood did you develop 'normally' e.g., did you have coordination problems, did you start puberty early or late, did you have nay speech/hearing/vision problems?

……

……

**SCHOOL & INTERESTS**

What type of schooling did you experience? e.g., religious/private/same sex schools etc.

……

Briefly describe your schooling experience. What were your strengths and weaknesses at school?
(e.g., English was easier than maths. Did you make friends easily? Did you experience bullying? Did you get along with teachers/authority figures?)

……

……

Did you have any interests outside of school such as sports, dancing, theatre, equestrian events?

……

……

Did you reach a high level of achievement? ……

Are you still participating in some of these activities now? ……

Do you think you are a competitive person? ……

**FAMILY**

Did you have a supportive family? ……

Or have you had to separate yourself and find outside support? ……

If so, do you feel you have had good people in your life? ……

Do you know of any medical problems running in the family?
(e.g., cancers, diabetes, heart problems, joint problems, emotional problems, addiction problems etc. Please list the problems)

……

……

**DAILY HABITS**

Please list any allergies that you have. This can be medications, food, insects, dust, pollens etc.

……

……

Do you feel that you are sensitive to chemicals? (e. perfumes give you a headache, taking one Panadol will sedate you, or drinking coffee will keep you awake?

……

……

Alcohol use (type and frequency) ……

Do you smoke? ……

If so, how much and what do you smoke? What triggers you to smoke? DO you know why you smoke?

……

Do you use speed, ecstasy, cannabis, heroin, any illicit drugs? If so, how much and how often?

……

Do you drink energy drinks such as red bull? If so, how much, which type and how often?

……

Do you drink soft drinks? If so, how much? ……

Do you drink tea or coffee? If so, how much? ……

Do you drink water? How much per day? ……

List what you would eat for

- breakfast on a typical day? ……
- mid morning?…… ……
- lunch on a typical day? ……
- afternoon? ……
- dinner? ……

What are your favourite foods?……

How often do you eat out? How often do you buy takeaway food? List what type of food you would have?

……

Have you ever fasted? If so, for how long? ……

Have you ever been on specific diets? e.g., raw food, paleo, Atkins etc.

……

……

What is your height? ……

What is your weight? .....

Do you exercise? If so, what do you do and how often?

.....

.....

Do you enjoy exercise? .....

Do you play any sports? Please list.....

.....

**MENTAL HEALTH**

Do you have any symptoms of depression or anxiety? .....

Do you feel stressed? .....

What are some stressors in your life at the moment? .....

.....

**WELLNESS & SPIRITUALITY**

What is your sleep pattern like?.....

Do you have any problems with sleep? (e.g., you find it hard to get to sleep, or you wake early)

.....

Do you snore? Do you have sleep apnoea and need to use an aide such as cpap?.....

How to you relax?.....

Do you practice meditation? If so, for how long and how often? .....

Please comment on your expectations about your health and wellbeing?
Do you have any goals? If so, please list:

.....

.....

Do you find it hard to make changes? Is it hard for you to stick to new ways of living? .....

What motivates you? .....

How do you think you learn?(e.g. are you more a visual, or tactile person?.....

What things do you understand easily? .....

Do you take time out to reflect on your life, relationships etc? ……

Do you practice any religion? ……

Would you describe yourself as a spiritual person or an atheist? ……

Are your family or significant friends identified as a particular religion? ……

**MEDICAL ISSUES**

Other doctors you see/ have seen? ……

Please list any surgeries you have had. ……

……

Please list any joint, bone or muscle problems……

……

List any problems you have with your eyes. ……

Do you need glasses? ……

List any problems regarding your hearing ……

List any problems regarding your nose and throat e.g., recurrent sore throat, blocked nose. Please include any issues:

……

List any problems regarding your stomach, bowel, liver, spleen, gall bladder, pancreas.

……

What is your usual pattern in relation to passing stools? e.g., constipation, diarrhoea, blood in stool, mucous in stool?

……

List any problems you have regarding your bladder and kidneys e.g., frequ3ent urinary infections, kidney stones.

……

List any problems you have ever had, or suffer from ongoing sexually transmitted diseases? Please list.

……

Please describe your menstrual cycle e.g., regular, painful, heavy flow, flooding, age period started?

……

Have you been pregnant? ……

# Wellness Health Questionnaire

Do you have children? ……

When was your last pap smear/ cervical screening test? ……

Have they been normal? ……

List any problems with your lungs. ……

List any problems you have with your skin e.g., acne, dermatitis, loss of hair etc.

……

List any problems regarding your heart e.g., any issues with blood pressure, irregular heartbeats, chest pains.

……

List any problems regarding your emotional wellbeing e.g., episodes of depression, anxiety, self-harm, suicide attempts etc.

……

Do you suffer with headaches, migraines, epilepsy? If so, please describe:

……

Do you have any problems with your temper? Are you easily irritated, confused, memory problems, poor coordination, loss of balance?

……

Have you experienced any head injuries? Have you been in any significant car/work accidents?
Please list any long-term problems.

……

Is there anything else that you feel is important for me to know?

……

……

……

*Please bring this completed form and signed consent form (page 8) to your first Integrated Derm appointment. Your first appointment is 60 minutes, allowing time for you and Dr Timms to go through the questionnaire you have completed, establish goals and organise applicable tests.*

*The cost for this Initial appointment is $350 and payment is required at the time of consultation. A Medicare rebate is available for this appointment. Visit our website www.tamarskinclinic.com.au for more information. Tamar Skin Clinic is located at 54 Invermay Road, Invermay ,7248.*

# General consent form for patients receiving Integrative Medicine Treatment

Integrative Medicine is a healing orientated medicine that aims to be inclusive of the whole person, including all aspects of lifestyle. It emphasizes the therapeutic relationship between practitioner and patient, is informed by evidence and makes use of all appropriate therapies.

I understand that this service combines conventional and what is considered complimentary medicine.

Dr Timms will inform me:

1. Which treatments are supported by empirical and/or scientific knowledge: and
2. Of any known risks associated with using an Integrated Medicine treatment.

I acknowledge that Integrative Medicine information, data and drug/herb/supplement interaction databases are constantly updated as new research becomes available, and due to the evolving nature of this field unforeseen complications and risks may eventuate.

I would like to take responsibility for my health care and to participate as a 'partner' in any decision making. I acknowledge the importance of lifestyle and prevention in maintaining good health.

I understand that some of the recommended tests and treatments may not be covered by Medicare or private health insurance funds, and I will be informed of the costs at the time of my consultations with Dr Timms.

By signing this document, I acknowledge that I have read and understood the information on this form.

Signature: _____ Print name: _____

Date: _____