



COMPOUNDING CHEMIST

Tree of Life

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Sawtell, NSW 2452

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HEALTH APPRAISAL

ADMIN ONLY

Doctor:
Blood Pressure:
Medication:
Tests Ordered:

Tongue:
Nails:
Iridology:
Notes:

Name:
Address:
Phone:
Email:



Health Concerns

Please describe your health condition and concerns:

What is your main ailment:

When did this condition develop:

Do any activities or food make the condition worse?:

Current treatment:

Current medication/supplements:

Please list and date any surgery, fractures, accidents:

Activity Level

Sedentary



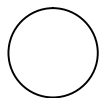
Light



Moderate



Athletic



METABOLIC BIOTYPES

Please tick any boxes that are relevant to determine your biotype

Undermethylation (Histadelia) 22%	Overmethylation (Histapenia) 8%	Pyrroluria (Zinc Depletes) (High H.P.L hydroxyhempyrolin)
Self motivated (high)	Poor motivation	Poor stress tolerance
High achiever before illness	Poor achiever	Anxiety/panic/fear
Strong willed/stubborn/inflexible	Artistic/musical/sculpture	Easily fatigued
My way/thoughts are correct	High anxiety/panic/nervous	Morning nausea
Perfectionism/procrastinates	Easily frustrated	Mood swings/instability
Addictive behaviour (anything)	May stutter	Explosive temper
High energy (if well)	Fatigue common	Motion sickness
Obsessional (OCD) (ODD)	Overweight/obesity	Intolerance of annoyances
Poor compliance	Hirsute/hairy	Irritability
High libido	Increased dental caries	Sensory (smell, noise, glare)
Social isolation	Food/chemical sensitivities	Sensitivity
Easy tearfulness	High pain threshold	Tag cutter
Collects things	Prone to osteoarthritis	Poor or no dream recall (B6)
Difficult transitions	Past Hx ADHD	Under-achievement at school
Walks slowly/motionless	Tinnitus often	Obsessed with smells
Low pain threshold	Stubby fingers	Fear of plane travel
Ruminations about the past	Young looking body	Behaviour/learning problems
Calm demeanour but high inner tension and anxiety	Eczema/dry skin	Violence potential
Denial of illness	Slow metabolism	Delay/skip breakfast
Heat intolerant	Better on vegetables	Hate mornings
Not caring about what people think	Often late	Obsessions about disaster
Frequent headaches/migraines	Expects perfections in others	Poor short term memory
Can have severe insomnia but often sleeps less	Concerned by what others think of them	Impulsivity
Sparse hair growth/slender	REACTS badly to anti-histamines and anti-depressants	Hyperactivity
prominent veins	Sleep disorder	Denies any problems
Elongated fingers and toes	Rarely has colds	Food & chemical sensitivities (1:6)
Fear of failure	Upper body pain	Inability to tan/ pale skin
Better on animal protein	Restless/nervous legs	Poor growth (low zinc)
Hears pulse at night	Caring and empathy	Premature greying/ dry skin
Seasonal allergies	Generous/kind/ loving	Stretch marks (low zinc)
Fast metabolism	Not keen on sport	Poor muscle development
Risk-taking	Depression	Acne (low zinc)
Sudden breakdown	Self mutilation	Severe depression
Delusions (not external voices) more than hallucinations	Self isolation	Paranoia
Phobias	Paranoia/less obsessions	Liable mood
Catatonic/psychosis	Hyperactive psychosis	Long recovery from anger/violent outbursts
Anorexia/bulimia	Religiosity	Physical acting out
S.A.D	Grandiosity	Losing control
	Mania	Poor immune function (low zinc)

Medical History

Health History: You and Your Family -any of the following that apply to you or your family-past or present

Condition	You	Family Member/List
Addictions/Alcohol		
Arthritis		
Anxiety/Depression		
Asthma/Bronchitis		
Autoimmune Disease		
Bladder/Kidney		
Bone Loss/ Osteo		
Cancer		
Diabetes		
Digestive/Intestinal Issues		
Ear/Eye Problems		
Eating Disorders		
Genetic Conditions		
Headaches		
Heart Disease		
High Blood Pressure		

Condition	You	Family Member/List
HIV/AIDS		
Hormonal Problems		
Hyperactivity/ADHD		
Learning Disability/PDD		
Muscle Problems		
Neurological Problems		
Psychological Problems		
Rheumatic Fever		
Sex Transmitted Diseases		
Seizure Disorders		
Sinus/Respiratory		
Skin Prob/Eczema/Acne		
Stroke		
Thyroid Disease		
Viral Disorders		
Weight Loss/Gain		

Health Appraisal – Brief

0 = Never	1 = Occasionally	2 = Moderate	3 = Severe
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PART 1 GASTROINTESTINAL

Section A HYPOACIDITY

Indigestion	0	1	2	3
Belching, burping	0	1	2	3
Gas after eating	0	1	2	3
Sense of fullness during meal	0	1	2	3
Poor appetite, picky eater	0	1	2	3
Difficult bowel movements	0	1	2	3
History of anaemia	N		Y (10)	
Vegetarian- no eggs, dairy	N		Y (5)	
Spoon shaped nails	N		Y (3)	
Unintentional weight loss	N		Y (3)	
Partial loss of taste/smell	N		Y (3)	

TOTAL POINTS _____

Section B SMALL INTESTINE/PANCREAS

Indigestion and fullness- lasts 2-4 hours after eating	0	1	2	3
pain tenderness, soreness on left-side under rib cage	0	1	2	3
Bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Abdominal cramps/aches	0	1	2	3
Nausea/and or vomiting	0	1	2	3
Specific foods/beverage – aggravate indigestion	0	1	2	3
Fibre cause constipation	0	1	2	3
Three or more large bowel-movements per day	0	1	2	3
Alternating constipation-and diarrhoea	0	1	2	3
Undigested food in stool	0	1	2	3
Mucus in stool	0	1	2	3
Dry, flaky skin, brittle hair	N		Y (3)	
Difficulty gaining weight	N		Y (3)	

TOTAL POINTS _____

Section C HYPERACIDITY

Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
Feeling hungry 1 or 2 hours after eating	0	1	2	3
Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
Heartburn, especially when lying down or bending forward	0	1	2	3
Heartburn due to spicy food, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
Difficulty or pain when swallowing	0	1	2	3
Chest pain or infections	0	1	2	3
Carbonated beverages, cream/milk give temporary relief from symptoms	0	1	2	3
Constipation	0	1	2	3
Black, tarry stool	0	1	2	3

TOTAL POINTS _____

Section D COLON

Lower abdominal pain cramping or spasms	0	1	2	3
Lower abdominal pain, relief by passing stool or gas	0	1	2	3
Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
Diarrhoea (loose watery)	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Painful difficult straining during bowel movements	0	1	2	3
Hard, dry or small stool	0	1	2	3
Feels bowels do not empty completely	0	1	2	3
Bright red blood following bowel movement	0	1	2	3
Anal itching	0	1	2	3

TOTAL POINTS _____

PART II DETOX METABOLISM

Section A LIVER/GALLBLADDER/PANCREAS

Moderate to severe pain under right side of ribcage	0	1	2	3
Abdominal pain worsens with deep breathing	0	1	2	3
Regurgitate bitter food	0	1	2	3
Bloated, feeling full	0	1	2	3
Belching, heartburn, gas	0	1	2	3
Fatty foods cause indigestion	0	1	2	3
Nausea or vomiting	0	1	2	3
Feels restless, agitated, angry	0	1	2	3
Unexplained itchy skin, worse at night	0	1	2	3
Stool colour alternates from clay brown to normal brown	0	1	2	3
Feeling of poor health	0	1	2	3
Fatigue, weakness, exhaustion	0	1	2	3
Unable to concentrate, irritable confused	0	1	2	3
Swollen feet or legs	0	1	2	3
Easy bruising	0	1	2	3
Feeling of extreme dryness	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dark urine, diminished flow	0	1	2	3
Dry flaky skin/hair	0	1	2	3
Yellowish cast to skin, eyes	0	1	2	3

TOTAL POINTS _____

Section B *HYPOTHYROID*

Fatigue, sluggish	0	1	2	3
Feels cold hand, feet	0	1	2	3
Difficult, infrequent bowel movement	0	1	2	3
Dryness skin, hair	0	1	2	3
Thick brittle nails	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Puffy face, hands, feet	0	1	2	3
Swollen upper eyelids	0	1	2	3
Eyeballs move involuntary	0	1	2	3
Muscles weak/cramp, tremble	0	1	2	3
Slow mental processes, forgetful	0	1	2	3
Slow heart beat	0	1	2	3
Loss of appetite	0	1	2	3
Abnormal swelling	0	1	2	3
Unsteady gait movements	0	1	2	3
Lack of interest in sex	0	1	2	3
Premenstrual tension	0	1	2	3
Infertility	0	1	2	3
Heavy menstrual bleeding	0	1	2	3
Gain weight easily	0	1	2	3
Swelling of the neck	0	1	2	3
Thinning hair on scalp, face and genitals	0	1	2	3

TOTAL POINTS _____

PART III IMMUNE FUNCTION

Progressive, mild fatigue after exertion or stress	0	1	2	3
General weakness	0	1	2	3
Blurred vision, dizzy when rising	0	1	2	3
Depression	0	1	2	3
Rapid mood swings	0	1	2	3
Irritable, nervous	0	1	2	3
Dark circles under eyes	0	1	2	3
Disinterest in food	0	1	2	3
Abdominal pain	0	1	2	3
Indigestion	0	1	2	3
Blotchy skin (white patches)	0	1	2	3
Tan skin-no sun	0	1	2	3
Black freckles on upper forehead, face or neck	0	1	2	3
Craving for salty food	0	1	2	3
Gradual loss of body hair	N		Y (3)	
Sensitive to minor changes in weather and surroundings	N		Y (5)	

TOTAL POINTS _____

PART IV MUSCULOSKELETAL

SECTION A BONE DENSITY

Generalised bone tenderness and aches	0	1	2	3
Localised bone pain	0	1	2	3
Bone deformity or swelling	0	1	2	3
Shins hurt during or after exercise	0	1	2	3
Low back or hip pain	0	1	2	3
Walking difficulties, limp	0	1	2	3
Crunching or creaking sounds when moving joints	0	1	2	3
Hands, feet, throat spasm or numb	0	1	2	3
Joint pain, stiffness, especially spine, hips, knee	0	1	2	3
Hearing loss, headaches, ringing ears	0	1	2	3
Established bone loss	N		Y (10)	
Calcium deposits	N		Y (6)	
Spinal curvature	N		Y (10)	
Recent loss of height	N		Y (10)	
Bow legs	N		Y (5)	
Stooped posture	N		Y (5)	
Hump at base of neck	N		Y (5)	
Unexplained bone fracture	N		Y (10)	
Tooth loss, gum disease	N		Y (3)	

PART IV (continued)

Section B MUSCLE

Generalised muscle aches and pains	0	1	2	3
Localised muscle stiffness, tension, pain	0	1	2	3
Specific body points feel sore when pressed	0	1	2	3
Headaches	0	1	2	3
Fatigued, tired, sluggish	0	1	2	3
Difficulty sleeping	0	1	2	3
Feel unrefreshed when waking	0	1	2	3
Muscle weakness or loss	0	1	2	3
Difficulty speaking or swallowing	0	1	2	3
Muscle cramps or spasms	0	1	2	3
Muscles twitch or tremble, eyelids, thumb, calf muscle	0	1	2	3
Irresistible urge to move legs	0	1	2	3
Legs move during sleep	0	1	2	3
Numbing, tingling sensation	0	1	2	3
Excessive joint mobility	0	1	2	3
Unable to fully straighten or extend legs or arms	0	1	2	3
Upper or lower back pain	0	1	2	3

TOTAL POINTS _____

Section C CONNECTIVE TISSUE

Joint stiffness, soreness	0	1	2	3
Red swollen, painful joints	0	1	2	3
Joint stiffness improves with rest, worsens with movement	0	1	2	3
Cracking joints	0	1	2	3
Shooting, aching, tingling pain down the back of leg	0	1	2	3
Joint pain involves one or more joints	0	1	2	3
Joints hurt when moving or when carrying weight	0	1	2	3
Limited range of motion	0	1	2	3
Difficulty standing up from seated position	0	1	2	3
Difficulty chewing food or opening mouth	0	1	2	3
Numbness, prickling, tingling sensation in the neck, shoulder, arm	0	1	2	3
Involuntary muscle spasms	0	1	2	3
Injury, sprain, strain easily	0	1	2	3
Discomfort or pain in neck, shoulder or arm	0	1	2	3
Knobby overgrowths on the joints close to fingertips	N		Y (5)	
Double jointed	N		Y (5)	
One led shorter than the other	N		Y (5)	

TOTAL POINTS _____

Food & Lifestyle Journal~ 5 days

Date:

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SLEEP PATTERN
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:

INFORMED CONSENT FORM FOR TREE OF LIFE COMPOUNDING AND WELLNESS CENTRE

I have had the opportunity to discuss with my Natural Therapist named below, the nature and purpose of the recommended natural therapies treatment.

I understand and I am informed that as in all health care in the practice of natural therapies, there may be some slight risks to treatment, including reaction to prescribed Vitamin, Herbal, Homoeopathic remedies and/ or some initial discomfort or reaction to massage or body work procedures.

My practitioner has explained that in many cases this is simply the body adjusting as it makes the changes.

I do not expect my practitioner to be able to anticipate and explain all risks and complications and wish to rely on my therapist to exercise his or her judgement during the course of the prescribed treatment and to make the corrections he/she feels is necessary at the time, based on the facts then known is in my best interest.

I hereby and request and consent to the prescribed course of treatment and procedures by the practitioner named below and that I have had the opportunity to ask questions about treatments.

I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition/s for which I seek treatment.

Print clients name: _____

Client's signature: _____

Date: _____

Witness to the clients signature

Practitioners name: _____

Practitioners address: _____