Steven Mouratidis
BSc,ND,MH,MATMS,NAET,NMT

9855 2249 (All Locations)	87 Denmark Street Kew Vic 3101	Suite 117/55 Flemington Road North Melbourne Vic 3051

Last Name:	First Name:	Initial:
Date of Visit:	Date of Birth:	Referred by:
Name of Parents or Guardians if under 18:		
Address:		
Suburb:	State:	Postcode:
Phone:	Work:	Mobile:
Email:	Name of Health Insurance:	
Current Occupation:		
Past Occupations:		

Present Conditions/Symptoms
How did it Happen? When did it Happen? Why do you feel it Happened?
Drugs: Do you take or have you taken any drugs for this or other conditions? (Include prescription, oral contraceptives, Lifestyle drugs)

Are you a smoker?	Have you been a smoker?

Do you have serious allergies and/or anaphylaxis to anything? If so, Which Ones?

Women Only – Are you Pregnant?	How many amalgams do you have or had?

Describe your present emotional state:
Did you have any past emotional traumas that still affect / or affected your health?
Past Medical History
Family History

Payment is expected at the time of service

PLEASE TURN OVER PAGE

Please list everything you eat or drink in a typical day

Breakfast	Lunch	Dinner
Snacks		

Drinks	How many glasses per day?
Water	
Coffee / Tea / Cola / Gurana etc	
Alcohol – Wine / Beer / Spirits etc	

Dietary supplements (Vitamins, herbs, etc)

Product	Daily Amount

Exercise	Type	How much per week
Cardiovascular	Running	
	Swimming	
	Team Sports	
Strength Training		

Hobbies:
Past:
Present:

Relationships

Rate them accordingly – 1 = Satisfying. 2 = Bearable, 3 = Strained, 4 = Nonexistent

Spouse	Children	Parents	In-Laws
Relatives	**Friends**	**Boss**	**Co-Workers**

Stress – What causes you stress?
Strength – What gives you strength?
Sleeping Patterns
What type of music do you listen to? Other relevant Information: