Autonomic Response Testing

Australia Comprehensive Health History

Thank you for taking the time to fill in this form as thoroughly as possible. This intake form is very detailed but it helps me to identify as many clues as possible towards balancing your health.

Together we can identify any foundational health priorities that are affecting your health. There are seven factors that I look at that can block your body. Once identified we can work on restoring balance so the body can self heal. Some of these seven issues will be important for you. Some of them will not.

Please take your time to complete this intake and be as honest as possible, but please leave any personal questions that make you uncomfortable. There is no judgement here and your answers will help me to best identify how to assist you.

1. GETTING TO KNOW YOU

Personal Information

First name

Last name

Address

Phone

Gender

Date of Birth

Email

Next of Kin

Relationship

Phone

Occupation

Hours Worked

Describe your first main concern and how it typically presents:

Describe your second main concern (if any):

Describe your third main concern (if any):

Describe your second main concern (if any):

Describe your third main concern (if any):

Describe your fourth main concern (if any):

Describe your fifth main concern (if any):

What diagnoses or explanations have been given to you?

Is there anything in your medical history (even from childhood) that you consider to be relevant?

Does anyone in your family experience similar symptoms to you?

Please list all PRESCRIPTION medication you are currently taking on a regular basis.

	Medicine	Dose	Frequency	Why Taken
1				
2				
3				
4				
5				
6				

Please list all NON-PRESCRIPTION medication and SUPPLEMENTS you are currently taking on a regular basis.

	Supplement	Dose	Frequency	Why Taken
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Do you take recreational drugs? ☐ Yes ☐ No

Do you have any scars on your body? If so where? ☐ Yes ☐ No

Wear glasses, jewelry or watches on a daily basis? ☐ Yes ☐ No

Wearable devices- Apple watch, Fitbit, CGM? ☐ Yes ☐ No

Have you had any head, neck, or back injuries? if yes, please explain. ☐ Yes ☐ No

Have you had the COVID vaccine? If so how many? ☐ Yes ☐ No

Please list ANY medications, anaesthetics, immunization or supplements you have had a severe or allergic reaction to.

	Name	Type of Adverse Effect	Age	Year
1				
2				
3				
4				
5				

Have you ever had an emergency injection of adrenaline (epinephrine) for a reaction to any medication, food, insect sting, or other substance? ☐ Yes ☐ No

Have you had any of the following operations?

OPERATION	Date
Appendectomy	
Ceasarean Section	
Dental Root Canals	
Dental Surgery	
Gallbladder Removed	
Hysterectomy	
Breast Implants	
Piercings or Tattoos	
Tonsillectomy	
Wisdom Tooth Removal	
Other	

Are you considering or do you have planned any surgical or medical procedures? ☐ Yes ☐ No

If yes, what surgical or medical procedures?

Do You Have Any Metal Implants In Your Body?

Examples	Date
Dental Amalgams	
Knee Replacement	
Metal Plates or Mesh	
Screws or Staples Form Surgery	
Other	

What are the metallic implants made of?

Triggering Events

If not relevant then please just write nil

Event	Details
When was the last time you felt well?	
Have you taken antibiotics in the last four years? If so was when and was it more than one type (e.g. double or triple therapy)?	
Have you ever experienced significant symptoms when travelling?	
Did you have a major loss or stressful event immediately prior to becoming unwell?	
Were there any major life change immediately prior to becoming unwell?	
Did you start or cease any medication around the time you becoming unwell?	
Was there a major structural change (back injury, surgical operation, teeth extractions) prior to becoming unwell?	
Were you bitten by a tick or have a bullseye rash immediately prior to becoming unwell?	
Did you move houses immediately prior to becoming unwell?	
Was there anything else significant that happened immediately prior to becoming unwell?	

2. TOXIN EXPOSURE

Please check any items that you are currently using or exposed to.

Mercury

Source	Check if Yes
Amalgam fillings	☐
Amalgam removal	☐
Mother had amalgams	☐
Flu, allergy, vaccine shots	☐
Tattoos with red ink	☐
Eat swordfish, tuna, shark or farmed salmon	☐

Aluminium

Source	Check if Yes
Vaccines	☐
Antiperspirants	☐
Aluminium foil	☐
Aluminium containers cans (soda, beer, juice)	☐
Aluminium utensils	☐
Aluminium cookware, and drinkware, water bottles	☐
Amalgam fillings	☐

Lead

Source	Check if Yes
Lead pipes	☐
Lead paint	☐
Leaded fuel	☐
Lipstick	☐
Lead-glazed pottery	☐
Women in menopause (accumulated)	☐
Lived near petrol station or industrial plant	☐

Copper

Source	Check if Yes
Estrogen supplementation	☐
IUD's (intra-uterine devices)	☐
Copper water pipes	☐
Copper cookware	☐

Cadmium

Source	Check if Yes
Smoking cigarettes or marijuana	☐
Burning fossil fuels (coal or oil)	☐
Lived near petrol station or industrial plant	☐

If cigarettes or marijuana, how much per week, what type?

Arsenic

Source	Check if Yes
Non-organicpoultry	☐
Non-organic rice from India and China	☐

Water

Source	Check if Yes
Cooking with unfiltered tap water	☐
Drinking unfiltered tap water	☐
Showering or bathing in unfiltered tap water	☐
Drinking bottled water	☐

Type of Water Filter (if any):

Fragrances

Source	Check if Yes
Aerosol air fresheners	☐
Chemically scented air fresheners	☐
Chemically scented candles	☐
Chemically scented incense	☐
Chemically scented perfumes and fragrances	☐

Cleaning Products

Source	Check if Yes
Chemical cleaning products	☐
Synthetically fragranced cleaning products	☐
Aerosol products	☐
Dryer sheets	☐
Bleach	☐
Caustic drain cleaners	☐

Personal Care Products

Source	Check if Yes
Chemically fragranced	☐
Aerosol hair sprays	☐
Aluminium antiperspirants	☐
Chemical body lotions	☐
Chemical hair colouring/treatments	☐
Chemical mouthwashes	☐
Chemical shampoo/conditioners	☐
Chemical soaps	☐
Chemical and/or fluoride toothpastes	☐
Chemical hair straighteners	☐
Talcum powder	☐
Artificial colours and dyes	☐
Lice treatments	☐
Skin whiteners	☐
Chemical Makeup	☐
Chemical Lip Balm and Lipstick	☐
Chemical Nail Polishes	☐
Nails Done	☐
Chemical Sunscreen	☐
Tanning Agents	☐
Aerosol Sprays	☐
Prescription medication (daily)	☐

Pesticides

Source	Check if Yes
Use glyphosate or herbicides in the garden	☐
Live near a farm, timber plantation, gold course, turf supplier, or bowling green.	☐
Use pet flea products.	☐
Use lice shampoos	
Non Organic Produce	☐

Foods

Source	Check if Yes
Eat non-organic produce	☐
Drink Alcohol	☐
Eat meat raised with hormones and antibiotics (particularly pork and chicken)	☐

If you drink alcohol, how much per week, what type?

Plastics

Source	Check if Yes
Plastic storage bags	☐
Plastic food containers	☐
Plastic food wrap	☐
Plastic drink bottles	☐
Takeaway coffee cups	☐
Tinned food (lined with plastic)	☐
Heating Plastics	☐
Non Stick Porcelain	☐
Grease Proof Paper	☐

House

Source	Check if Yes
New Bedding	☐
Synthetic Bedding	☐
New Carpet	☐
New Furniture	☐
Synthetic Clothes	☐
Dry Cleaned Clothes	☐

Mould: either at home or work.

Source	Check if Yes
Flood	☐
Water intrusion (pipes, basement or roof)	☐
Visible mould	☐
Damp or mildew smell	☐
Cracked tiles or missing grout in the shower	☐
Holes or gaps in walls or windows	☐
Humidity over 50%	☐
Not serviced annually /cleaned air conditioner	☐
NON-Hepa filtered vacuum	☐
Don't dust and vacuum weekly	☐

EMFs

Source	Check if Yes
Use Wi-Fi (non ethernet) for the internet	☐
Cell Phones (Without Hands-Free or Speakerphone)	☐
Sleep with Phone (not on Aeroplane Mode)	☐
Use Mobile Phone in A Car	☐
Cordless Phones	☐
Sleep with Wi-Fi On	☐
Wireless Headsets (Blue Tooth)	☐
Wear a Fitbit	☐
Wireless Security System	☐
Wireless Baby Monitor	☐
Smart Meter	☐
Solar Panels	☐
Electrical Appliances in Bedroom	☐
Fridge, oven, solar inverter, electric hot water service, ducted heating unit, pool pump or meter panel/smart meter near or on the other side of the wall behind bed	☐
Dimmer Switches	☐

Metal Around Bed (Frame, Springs, Electric Blanket)	☐
If a multi-storey building, adjacent to a lift, switchboard or substation	☐
Live Near Cell Tower/Transformer within 400m	☐
High voltage transmission lines within 600m	☐
Exposure to Non-full Spectrum Lighting	☐
Blue Light Exposure After Dark	☐

How may Wi-Fi networks can you pick up whilst in your home?

3. GASTROINTESTINAL FUNCTION

Tick which is applicable

How often do you have a bowel movement?

- ☐ 1-3 times per day
- ☐ More than 3 times per day
- ☐ Not regularly every day

What is your bowel movement colour and consistency?

Do you regularly experience intestinal gas?

- Yes
- No
- Sometimes

4. NUTRITION AND HYDRATION

What percentage of your meals are home-cooked?

- <25%
- 25-50%
- 50-75%
- 75-100%
- 100%

If less than 75%, what is the barrier to increasing the %?

What kind of diet do you eat?

Please note any specific food restrictions that you have:

Do you have any known food allergies or intolerances? ☐ Yes ☐ No

Do you have any delayed symptoms after eating certain food such as fatigue, muscle aches, sinus congestion, ear aches? ☐ Yes ☐ No

Is there anything else I should know about your current diet or relationship with food? ☐ Yes ☐ No

If yes, what is important for me to know?

SLEEP & RELAXATION

Which of these statements describe your sleep patterns.

	Yes	No
I have trouble falling asleep?	☐	☐
I have trouble staying asleep?	☐	☐
I go to bed after 10.30pm	☐	☐
I awaken between 2-3 a.m.?	☐	☐
I feel rested and refreshed when I get up in the morning?	☐	☐
I recall my dreams?	☐	☐
I often have nightmares?	☐	☐
I use sleeping pills to get to sleep?	☐	☐
I use melatonin to sleep?	☐	☐

What time do you normally go to bed?

What time do you get up in the morning?

Do you typically have a snack before going to bed? ☐ Yes ☐ No

Do you have blue light exposure prior to going to bed? ☐ Yes ☐ No

Do you regularly spend time outside each day? ☐ Yes ☐ No

Is your energy good all day long? ☐ Yes ☐ No

When is your energy worst during the day?

Do you take time to rest and relax each day? ☐ Yes ☐ No

What do you do to rest and relax?

STRESS AND RESILIENCE

How is your mood in general? Do you experience more anxiety, depression, grief, or anger than you would like?

- ☐ Yes
- ☐ No
- ☐ Sometimes

Which if any of these types of stress have you had in your life? Please also rank on a scale of 1 - 10 (with 10 being extremely stressful, and 1 being not very stressful) how stressful the event is TODAY when you think about it. Can you also please indicate what emotional support (if any) you have used for the stressor.

Type of Stress	Yes	Year	Degree	Emotional Support
Loss of Someone Close	☐			
Illness in Someone Close	☐			
Loss of Job	☐			
Change of Job	☐			
Moving House	☐			
Marriage	☐			
Separation	☐			
Divorce	☐			
Pregnancy	☐			
Alcohol/drug Addiction	☐			
Addiction in Close Person	☐			
Physical Abuse	☐			
Emotional Abuse	☐			
Other	☐			
Other	☐			

If other, please specify

Is your home environment emotionally and spiritually uplifting? ☐ Yes ☐ No

Is your work environment generally a pleasant experience? ☐ Yes ☐ No

Do you have a regular emotional support routine? ☐ Yes ☐ No
(ie meditation, prayer, counselling)

This section is looking at inherited trauma. Please reflect on the last three generations of your family (both maternal and paternal). Was their life impacted by any traumatic events? For example, war, loss of a child, or loss of parents at a young age, stillborn child, death of a spouse etc. What is the most traumatic event in their life?

Family Member	Event	Their Age At Time Of Event

Do you have a regular spiritual or religious practice? ☐ Yes ☐ No

If it feels appropriate for you, please explain a little more about your spiritual practice:

EXERCISE & MOVEMENT

In an average per week, how much, and what type of exercise do you do?

How much per week	What type

IS THERE ANYTHING ELSE?

Is there anything else you want me to know?

THANKYOU

This information provides invaluable information to make our time together productive. My aim is to identify the factors which are preventing you from optimising your health. I look forward to working with you and supporting you.