

New client form

solutions to health

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private and confidential

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FULL NAME:		AGE:
D.O.B.	OCCUPATION:	
PHONE:	EMAIL:	
HEALTH FUND:	DOCTOR:	
ADDRESS:		
SIGN UP TO RECEIVE EMAILS ABOUT NEWS AND SPECIALS: Y / N ?		
HOW DID YOU HEAR ABOUT US?:		

MAIN MEDICAL HEALTH CONDITIONS / COMPLAINTS: (eg. Allergies, blood pressure variations, arthritis, recent infections or accidents)
MAIN REASON FOR YOUR VISIT:
CURRENT MEDICATIONS SUPPLEMENTS / HERBS / NATURAL REMEDIES (INCLUDE DOSE PER DAY):
KNOWN ALLEGIES / SENSITIVITIES / INTOLERANCES:

A SAMPLE OF YOUR DAILY DIET (Not your ideal diet, you honest average diet):			
BREAKFAST:			
LUNCH:			
DINNER:			
MORNING /AFTERNOON TEA:			
JUNK FOOD / TREATS / CRAVINGS:			
DAILY WATER INTAKE:	DAILY COFFEE/S:	DAILY TEA/S:	OTHER:
NOTE: PLEASE INCLUDE / BRING RELEVANT TEST RESULTS AND OR BLOOD WORK (available upon request from your GP).			
DISCLAIMER: Any recommendations, tests or supplementation are not intended as diagnostic or for treatment of serious diseases or health conditions but rather to provide naturopathic and nutritional support improvement of vitality, energy, health and general wellbeing.			