Confidential Patient Questionnaire

Please complete the following questionnaire. Your response remains confidential, provides valuable information and makes your initial assessment more efficient.

Title: Dr Mr Mrs Ms Miss

Name:_____

Postal Address: _____

Suburb_____

City_____

State: QLD NSW VIC WA SA NT

Postcode_____

Home Phone Number_____

Work Phone Number_____

Mobile_____

Email_____

Medicare Number_____ Reference:___ Exp:_____
(* Your reference is the number next to your name on the Medicare card)

Date of Birth _____

How did you hear about the Treat the Cause Clinic?

Yellow Pages □ Website □ Friend/relative □

Drove By □ Referral □ Brochure □

Newspaper □ Magazine □ Presentation □

Other_____

DR. GREG EMERSON
PHYSCIAN. PERMACULTUE FARMER.
WILDERNESS SURVIVAL

TREAT THE CAUSE CLINIC

DR. GREG EMERSON
MbChB DipDHM DipObs FACEM FACNEM
PROVIDER NO. 061864AT
3-4, 1 MOONEY STREET
LOGAN CENTRAL
BRISBANE, QLD 4114
P: + 61 (0)7 3339 7910
F: + 61 (0)7 3339 7920

General Consent Form and Authority to Obtain Information:

I _____(NAME),

Understand the following important points in relation to seeking and receiving treatment from Dr Greg Emerson:

(1) A comprehensive clinical assessment including an extensive clinical, nutritional, and environmental history, appropriate clinical examination, and indicated Pathology and Functional Biochemical testing are required to best identify potential causative factors of your symptoms / illness.
(2) The recommended Pathology and Functional Biochemical tests may not attract a Medicare Rebate. You will be advised of these costs (if any) at the time of consultation. These costs cover the testing kits (including ordering and storage), explanation of how the tests are to be conducted, conduction of the test(s), providing printed results with explanations, and providing a back up service to answer patient questions re testing procedures etc. These costs are paid directly to the Laboratory used on forwarding the specimen(s) for testing.
(3) Some of the recommended specialised Laboratory tests and Treat the Cause Clinic treatments may be outside the usual parameters of conventional Medicine in Australia, however they are supported by abundant clinical research and experience and respected Australian and International Medical Organisations such as Australasian College of Nutritional and Environmental Medicine, Australian Integrative Medicine Association , American Academy of Anti Ageing Medicine, and American College for the Advancement in Medicine. TTCC has access to a regularly updated clinical research library for patients who request this research information. There will be a fee payable if this information is required.
(4) Specific Nutrients / Products may be recommended as part of your treatment plan. In some cases a Compounding Pharmacist will be instructed to encapsulate the recommended nutrients. In other cases specific brand Nutrients will be recommended. These have been carefully sourced based on quality, clinical experience, efficacy, and cost. Therefore in most cases brand substitution is not recommended. These Nutrients are mostly made available to you at TTCC for the following reasons:
    (a) Convenience: it is not possible to purchase the specific Nutrients from a retail outlet as they are registered with the Therapeutics Goods Administration as

'Practitioner Only' products. It is possible to order these directly from the Manufacturer with a Practitioner order form (alternative purchasing option and these forms are available if preferred), however there will be an inevitable delay in receiving these.

(b) Certainty / Reassurance that you will receive the recommended Nutrients and not a brand substitution which may differ in quality, nutrient concentration or chemical form, or have other unnecessary nutrients included.

(c) Advice: you will receive information re precise dosage, timing, potential adverse effects and medicine – nutrient interactions to be aware of. Any concerns that arise whilst taking the recommended Nutrients can be answered by way of e mail.

(d) Reduced Cost: the delivery / postal cost is avoided that would otherwise be incurred with use of a direct order form. The purchase price of nutrients is held at the level of a direct order from the manufacturer.

(e) Profit Margin: TTCC uses profits from the sale of Nutrients / Products to cover the extra costs of providing the convenience of an in-house Dispensary for patients which includes ordering, secure storage, wastage, dispensing advice, staff training, and book keeping.

(5) Interstate patients: in some circumstances follow up consultations can be conducted via telephone. In this case it is important to understand that there is NO Medicare Rebate applicable.

(6) Your Clinical Records are securely stored and are only assessable by TTCC Health Practitioners who are bound by privacy laws to maintain the confidentiality of your clinical records.

(7) I give consent to TTCC to obtain clinical information and results from the following Doctors who have been involved in my care to assist in the assessment and management of my condition:

(8) If you wish your GP to be informed of your treatments please inform the treating Doctor. Treatments in most cases will not interfere with any existing medication / treatments but may over time allow for medication dosage reduction.

NAME: _____

SIGNATURE: _____

DATE: _____

What are the main problems you are experiencing?

_____
_____
_____
_____
_____

What do you think is causing the problems?

_____
_____
_____
_____
_____

What kind of treatments have you tried for the problem(s)? Please bring any relevant tests or investigations to the consultation with you.

_____
_____
_____
_____
_____

When did you last feel well?_____

What do you think would help you?

_____
_____
_____
_____
_____

Past Medical History (please tick)

Angina	□
Heart attack	□
High cholesterol	□
Peripheral vascular disease	□
Stroke	□
Bleeding disorder	□
High blood pressure	□
Cancer	□
Arthritis	□
Diabetes	□
Thyroid disease	□
Allergies	□
Stroke	□
Liver Disease	□
Kidney Disease	□
Asthma	□
Chronic Lung disease	□
Recurrent chest infections	□
Sinusitis	□
Stomach ulcers	□
Diverticular disease	□
Irritable bowel syndrome	□
Crohn's Disease/Ulcerative colitis	□
Reflux oesophagitis	□
Glandular fever	□
Operations	□
Known chemical or toxin exposure	□
Amalgam (mercury) fillings	□
Root canals	□
Eczema	□
Psoriasis	□
Sleep apnoea	□
Migraines	□
Fibroids	□
Premenstrual tension	□

Current Medications

Name	**Dose**

Nutritional Supplements

Name	**Dose**

Allergies (including medications, foods, mites, grasses and chemicals)

Name	**Dose**

Thank you for your time and patience in completing this form.

Allergy Questionnaire

Read each question carefully, and circle the number next to a question if it applies to you. When you finish, add up the numbers you have recorded.

Do you experience fatigue?	3
Do you have frequent headaches?	3
Do you experience sneezing, persistent runny or itchy nose?	4
Do you have frequent colds?	2
Do you experience dizziness?	4
Do you suffer from yearly sinus infections?	3
Do your eyes itch, water, get red or swell?	4
Do you have recurrent ear infections?	2
Do you have asthma, wheezing or chronic cough?	4
Do you have eczema, itchy skin, or hives?	3
Do you have indigestion, bloating, diarrhoea or constipation?	1
Do your symptoms worsen during a particular season?	4
Do your symptoms change when you go inside or outside?	3
Are your symptoms worse in parks or grassy areas?	4
Are your symptoms worse in your bedroom after going to bed?	2
Do you wake in the middle of the night with a blocked nose?	2
Are your symptoms worse in dusty areas?	4
Are your symptoms worse around animals?	2
Do you have any relatives with allergies?	2
Do you have mood swings or feel depressed for no reason?	1
Do you have recurrent yeast or fungal infections?	2
Do you develop symptoms after eating certain foods?	2
Do you sometimes feel stimulated or fatigued after meals?	2
Do you have dark circles under your eyes?	2
Do you have a crease across the bridge of your nose?	2
TOTAL SCORE	_____

< 9 allergies are unlikely	9-12 allergies are possible
13-30 allergies are probable	> 30 allergies very likely

Adrenal Questionnaire

Read each question carefully, and circle the number next to a question if it applies to you. When you finish, add up the numbers you have recorded.

Do you experience fatigue?	3
Do you have allergies?	3
Do you have asthma?	3
Do you have recurrent infections?	3
Are you under severe emotional stress?	3
Do you suffer from chronic pain or physical stress?	3
Do you have low blood pressure?	2
Do you have a low pulse rate (<70/min with no exercise)?	2
Do you feel faint when you rise quickly?	2
Do you experience depressed moods?	2
Do you experience joint pain?	2
Do you have muscle pain?	2
Do you have low libido?	2
Do you have hair loss?	2
Do you have anxiety attacks?	2
TOTAL SCORE	_____

<7 adrenal fatigue unlikely

7-12 adrenal fatigue possible

>12 adrenal fatigue very likely

Oestrogen Deficiency Questionnaire

Read each question carefully, and circle the number next to a question if it applies to you. When you finish, add up the numbers you have recorded.

Do you have hot flushes?	4
Do you have night sweats?	4
Do you have vaginal dryness?	3
Do you have to pass urine more frequently than you used to?	2
Are you depressed?	2
Do you have difficulty sleeping?	3
Have you lost interest in sex?	2
Have your periods stopped?	4
TOTAL SCORE	_____

< 5 oestrogen deficiency unlikely

5-9 oestrogen deficiency possible

> 9 oestrogen deficiency very likely

Oestrogen Dominance Questionnaire

Read each question carefully, and circle the number next to a question if it applies to you. When you finish, add up the numbers you have recorded.

Do you experience premenstrual breast tenderness?	4
Do you have premenstrual mood swings?	4
Do you experience premenstrual fluid retention and weight gain?	4
Do you experience premenstrual headaches?	4
Do you experience migraines?	3
Do you experience severe menstrual cramps?	4
Do you have heavy periods with clotting?	3
Do you have irregular menstrual cycles?	3
Do you have uterine fibroids?	3
Do you have fibrocystic breast disease?	3
Do you have endometriosis?	2
Have you had infertility problems?	2
Have you had more than one miscarriage?	2
Do you experience joint pain?	1
Do you experience unusual muscle pain?	1
Do you have a decreased libido?	3
Do you have anxiety or panic attacks?	2
TOTAL SCORE	_____

< 5 oestrogen dominance is unlikely
5-8 oestrogen dominance possible
9-20 oestrogen dominance probable
>20 oestrogen dominance is very likely

Testosterone Deficiency Questionnaire

Do you experience fatigue?	2
Has your sense of drive and purpose decreased?	3
Do you lack initiative?	3
Are you less assertive?	3
Has your sense of well-being declined?	2
Do you have depressed moods?	2
Are you frequently irritable?	2
Has your self-confidence declined?	2
Do you find it difficult to set goals?	2
Do you have a difficult time making decisions?	2
Has your mental sharpness declined?	2
Has your stamina and endurance lessened?	2
Have you lost muscle mass, strength or tone?	4
Have you gained body fat around your waist?	2
Is your cholesterol elevated?	2
Has your libido decreased?	4
Has your sexual ability declined?	2
Do you find it difficult to obtain or maintain an erection?	2
Do you have sleep apnoea?	2
TOTAL SCORE	_____

<7 testosterone deficiency unlikely
7-20 testosterone deficiency possible
> 20 testosterone deficiency very likely

Thyroid Questionnaire

Read each question carefully, and circle the number next to a question if it applies to you. When you finish, add up the numbers you have recorded.

Do you experience fatigue?	4
Do you have elevated cholesterol?	4
Do you have difficulty losing weight?	2
Do you have cold hands and feet?	2
Are you sensitive to cold?	2
Do you have difficulty thinking?	2
Do you find it hard to concentrate?	2
Do you have poor short-term memory?	2
Are your moods depressed?	2
Are you experiencing hair loss?	2
Do you have fewer than one bowel movement a day?	2
Do you have dry skin?	2
Do you have itchy skin during the winter?	1
Do you experience fluid retention?	2
Do you have recurrent headaches?	1
Do you sleep restlessly?	1
Are you tired when you awaken?	2
Do you have afternoon fatigue?	2
Do you experienced tingling or numbness in your hands or feet?	2
Do you experience decreased sweating?	2
Have you had problems with infertility or miscarriages?	2

Do you have recurrent infections?	2
Do your muscles ache?	2
Do you have joint pain?	2
Do you have thinning of your eyebrows or eyelashes?	2
Is your tongue enlarged?	2
Is your skin pasty, puffy or pale?	2
Do you have decreased body hair?	2
Is your voice hoarse?	1
Do you have a pulse less than 60?	2
Do you have low blood pressure?	2
Is your average early-morning temperature less than 36.6?	4
Do you have sleep apnoea?	2
TOTAL SCORE	_____

<11 unlikely you have low thyroid function

11-30 low thyroid function as a possibility

>30 low thyroid function is very likely

Yeast Overgrowth Questionnaire

Do you experience fatigue?	3
Do you feel lethargic?	2
Do you have recurrent vaginal yeast infections?	4
Have you taken antibiotics multiple times during your life?	3
Do you have abdominal bloating, cramping or gas?	3
Do you have indigestion or heartburn?	2
Do you have flushing, headache, congestion or itchy skin after alcohol?	2
Do you crave sugar or bread products?	2
Do you have difficulty concentrating?	1
Do you have depressed moods?	1
Do you develop skin rashes or hives?	2
Do you have athletes foot?	4
Do you have jock itch?	4
Do you have fungal infections under your toenails or fingernails?	3
Do you have allergy symptoms?	1
Do you have recurrent respiratory infections?	1
Do you experience joint pain?	1
Do you experience muscle pain?	1
TOTAL SCORE	_____

<10 yeast overgrowth unlikely
10-16 yeast overgrowth is a possibility
>16 yeast overgrowth is very likely

Section 1: Symptom Frequency Score

0 None 1 Mild 2 Moderate 3 Severe

1. Unexpected fevers, sweats, chills or flushing.
2. Unexplained weight loss or gain.
3. Fatigue.
4. Unexplained hair loss.
5. Swollen glands.
6. Sore throat.
7. Testicular or pelvic pain.
8. Unexplained menstrual irregularity
9. Unexplained breast milk production or breast pain.
10. Bladder irritation or dysfunction.
11. Sexual dysfunction or low libido.
12. Irritable bowel.
13. Constipation or diarrhoea.
14. Chest pain or rib soreness.
15. Shortness of breath or cough
16. Heart palpitations.
17. Painful soles of the feet.
18. Joint pain or swelling.
19. Stiffness of neck or back.
20. Muscle pain or cramps.
21. Twitching of face or other muscles.
22. Headaches.
23. Neck cracking.
24. Tingling, numbness or burning sensations.
25. Facial paralysis (Bell's palsy).
26. Vision blurry or double.
27. Ears- buzzing, ringing, or painful.
28. Vertigo.
29. Light headedness.
30. Tremor.
31. Confusion, foggy brain.
32. Poor concentration.
33. Poor short term memory.
34. Disorientation.
35. Difficulty with speech or writing.
36. Mood swings, irritable, depression.
37. Disturbed sleep- too much/too little.
38. Worse hangover.

Add up total for section 1_____

Section 2: Most Common Lyme Symptoms Score

If you rated a 3 for each of the following in section 1, give yourself 5 additional points:

- Fatigue
- Poor short term memory
- Joint pain or swelling
- Tingling, numbness or burning sensations.
- Sleep- too much/ too little

Score for Section 2 _____

Section 3: Lyme Incidence Score

Circle the points for each of the following statements you agree with.

1. You have had a tick bite with no rash or flu symptoms. *3 points*
2. You have had a tick bite followed by a rash or flu symptoms. *5 points*
3. You live or have visited what is considered a Lyme- endemic area. *2 points*
4. You have a family member who has been diagnosed with Lyme or another tick borne infection. *1 point*
5. You experience migratory muscle pain. *4 points*
6. You experience migratory joint pain. *4 points*
7. You experience tingling/burning/numbness that migrates or comes and goes. 4 points
8. You have previously been diagnosed with chronic fatigue syndrome or fibromyalgia. *3 points*
9. You have been previously diagnosed with an autoimmune disease (like lupus, MS or rheumatoid arthritis). *3 points*
10. You have a positive Lyme test. *5 points*

Score for Section 3 _____

Section 4: Overall Health Score

1. Thinking about your overall physical health, for how many of the past 30 days was your physical health not good? _____ days
   Points:
   0-5 days = 1 point
   6-12 days = 2 points
   13-20 days = 3 points
   21-30 days = 4 points

2. Thinking about your overall mental health, for how many of the past 30 days was your mental health not good? _____ days
   Points:
   0-5 days = 1 point
   6-12 days = 2 points
   13-20 days = 3 points
   21-30 days = 4 points

   Total score for section 4/1 and 2_____

   SCORING
   Section 1 total _____
   Section 2 total _____
   Section 3 total _____
   Section 4 total _____

   FINAL SCORE _____

   Score of 46 or more- high probability of a tick borne disorder
   Score between 21 and 45- possible tick borne disorder
   Score under 21- unlikely to have a tick borne disorder