holistic integrated health

Dr Herman Spies

26 Olienhout Ave, Plattekloof 2, Parow, 7500.

Patient Details:

Surname: ______________________ Title: _____. Home Language: ____________.

Full Names 1. Main Member: ______________________ ID No.: ______________________.

2. Spouse: ______________________ ID No.: ______________________.

3. Child: ______________________ Birth Date: ______________________.

4. Child:______________________ Birth Date: ______________________.

5. Child:______________________ Birth Date: ______________________.

6. Child:______________________ Birth Date: ______________________.

Medical Aid Details:

Medical Aid Name: ______________________. Address: ______________________

Medical Aid Option: ______________________. ______________________

Medical Aid Number: ______________________. ______________________

Date Issued: ______________________. ______________________.

Addresses and Telephone Numbers:

Home Address: ______________________ Home Tel. No.: ______________________.

______________________ Cell. No. Main Member: ______________________.

______________________. Cell. No. Spouse: ______________________.

Postal Address: ______________________ eMail Main Member: ______________________.

______________________ eMail Spouse: ______________________.

______________________.

Work Name & Address Main Member: ______________________ Work Tel. No.: ______________________.

____

______________________.

Work Name & Address Spouse: ______________________ Work Tel. No.: ______________________.

____

______________________.

Next of Kin: ______________________ Tel. No.: ______________________.

(Not Own Address) ______________________

____

____

____

______________________.

New Patient Details & History

Full name/s of patient: ____

Name known by: ____ Male ____ Female: _______

Date of birth: ______________________________________ Current Age _____________

Own Birth: Natural: (___) / Cesarean Section: (___) Breastfed: (No) / (Yes) ____ (Months) ________

Females: Times Pregnant: _______ Live born children: _______ Miscarriages: _______

Females: Contraception used (In the past): Yes: ______ / No: ______. Type: __________________________

Contraception used (Currently): Yes: ______ / No: ______. Type: __________________________

Marital Status: ______________________ Occupation: ____

Hobbies: ____

Blood Group: ________________________ (Handy but not essential).

Family History & Birth.

Diseases occurring often in Father's family: ____

Father's Health (if still alive) or cause of death and at what age? __________________________________

Diseases occurring often in Mother's family: ____

Mother's Health (if still alive) or cause of death and at what age? __________________________________

Problems with your mother's health or your health during her pregnancy with you: ___________________

Problems during your mother's birth process with you: ____

Number of Siblings (Brothers & Sisters): _____

Status of health of siblings:	Current Age:

Previous Surgery:

Procedure: Year:

____ ____________
____ ____________
____ ____________
____ ____________
____ ____________
____ ____________

Allergies: ____

____
____

Important events that lead to deterioration in health: ____________________

____
____
____
____
____
____

Physical Activity:

Type:	Times a Week:	Duration:

Chronic conditions already diagnosed & any Prescription medication currently taken for the condition/s:

Year Diagnosed:	Condition:	Prescription Medicine/s taken & Dosage:

Sources of Water:

Main Source: Tap ______ / Bottle ______ / Filter ______ Filter brand name ____________________

Alternative Source: Tap ______ / Bottle ______ / Filter ______ Brand name ____________________

Meals:

I eat breakfast ____ times a week. My typical breakfast is: ____

____

I eat lunch ____ times a week. My typical lunch is: ____

____

I eat supper ____ times a week. My typical supper is: ____

____

Natural Medicines or Herbs or Supplements taken:

Name:	Brand:	Quantity per Day:

Bowel Movement:

Current frequency of bowel movement: _____ per day / _____ per week.

Stools: Normal: _____ Hard: _____ Loose: _____ Colour: ______________ Float/Sink: _____________

Habits:

Smoking: In the Past (Yes/No) _____ Quantity ______ Currently (Yes/No) ______ Quantity ________

Coffee/caffeinated beverages like energy/diet drinks, colas, or black/green teas: Cups per day: _____

Alcohol: Daily _____ Weekly ______ Occasional _____ Quantity _____ Previous addiction ________

Other Addictive substances; Please specify ____

Current Complaints in order of priority:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

DETOXIFICATION QUESTIONNAIRE

Rate each of the following symptoms based on your typical health profile for the specified duration:

✓ Past month

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD
_______ Headaches
_______ Faintness
_______ Dizziness
_______ Insomnia **TOTAL** _______

EYES
_______ Watery or itchy eyes
_______ Swollen, reddened or sticky eyelids
_______ Bags or dark circles under eyes
_______ Blurred or tunnel vision **TOTAL** _______

EARS
_______ Itchy ears
_______ Earaches, ear infections
_______ Drainage from ear
_______ Ringing in ears, hearing loss **TOTAL** _______

NOSE
_______ Stuffy nose
_______ Sinus problems
_______ Hay fever
_______ Sneezing attacks
_______ Excessive mucus formation **TOTAL** _______

MOUTH/ THROAT
_______ Chronic coughing
_______ Gagging, frequent need to clear throat
_______ Sore throat, hoarseness, loss of voice
_______ Swollen or discolored tongue, gums, lips
_______ Canker sores **TOTAL** _______

SKIN
_______ Acne
_______ Hives, rashes, dry skin
_______ Hair loss
_______ Flushing, hot flashes
_______ Excessive sweating **TOTAL** _______

HEART
_______ Chest pain
_______ Irregular or skipped heartbeat
_______ Rapid or pounding heartbeat **TOTAL** _______

LUNGS
_______ Chest congestion
_______ Asthma, bronchitis
_______ Shortness of breath
_______ Difficulty breathing **TOTAL** _______

DIGESTIVE TRACT
_______ Nausea, vomiting
_______ Diarrhea
_______ Constipation
_______ Bloated feeling
_______ Belching, passing gas
_______ Heartburn
_______ Intestinal/stomach pain **TOTAL** _______

JOINTS/ MUSCLE
_______ Pain or aches in joints
_______ Arthritis
_______ Stiffness or limitation of movement
_______ Feeling of weakness or tiredness
_______ Pain or aches in muscles **TOTAL** _______

WEIGHT
_______ Binge eating/drinking
_______ Craving certain foods
_______ Excessive weight
_______ Water retention
_______ Underweight
_______ Compulsive eating **TOTAL** _______

ENERGY/ ACTIVITY
_______ Fatigue, sluggishness
_______ Apathy, lethargy
_______ Hyperactivity
_______ Restlessness **TOTAL** _______

MIND
_______ Poor memory
_______ Confusion, poor comprehension
_______ Difficulty in making decisions
_______ Stuttering or stammering
_______ Slurred speech
_______ Learning disabilities
_______ Poor concentration
_______ Poor physical coordination **TOTAL** _______

EMOTIONS
_______ Mood swings
_______ Anxiety, fear, nervousness
_______ Anger, irritability, aggressiveness
_______ Depression **TOTAL** _______

OTHER
_______ Frequent illness
_______ Frequent or urgent urination
_______ Genital itch or discharge **TOTAL** _______

GRAND TOTAL **TOTAL** _______

Identi-T Stress Assessment

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, we can create a natural stress relief program for your individual needs.

Directions:
Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true   1 = Seldom true   2 = Sometimes true   3 = Often true

When under stress for two weeks or longer, I…

Section A:

1. Get wound up when I get tired and have trouble calming down	0	1	2	3
2. Feel driven, appear energetic but feel "burned out" and exhausted	0	1	2	3
3. Feel restless, agitated, anxious, and uneasy	0	1	2	3
4. Feel easily overwhelmed by emotion	0	1	2	3
5. Feel emotional - cry easily or laugh inappropriately	0	1	2	3
6. Experience heart palpitations or a pounding in my chest	0	1	2	3
7. Am short of breath	0	1	2	3
8. Am constipated	0	1	2	3
9. Feel warm, over-heated, and dry all over	0	1	2	3
10. Get mouth sores or sore tongue	0	1	2	3
11. Get hot flashes	0	1	2	3
12. Sleep less than seven hours a night	0	1	2	3
13. Have trouble falling asleep and staying asleep	0	1	2	3
14. Worry about high blood pressure, cholesterol, and triglycerides	0	1	2	3
15. Forget to eat and feel little hunger	0	1	2	3

Combined Score of all Columns in Section A: ______

Section B:

1. Find myself worrying about things big and small	0	1	2	3
2. Feel like I can't stop worrying, even though I want to	0	1	2	3
3. Feel impulsive, pent up, and ready to explode	0	1	2	3
4. Get muscle spasms	0	1	2	3
5. Feel aggressive, unyielding, or inflexible when pressed for time	0	1	2	3
6. See, hear, and smell things that others do not	0	1	2	3
7. Stay awake replaying the events of the day or planning for tomorrow	0	1	2	3
8. Have upsetting thoughts or images enter my mind again and again	0	1	2	3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over	0	1	2	3
10. Worry a lot about terrible things that could happen if I'm not careful	0	1	2	3

Combined Score of all Columns in Section B:

Section C:

1. Have muscle and joint pains	0	1	2	3
2. Have muscle weakness	0	1	2	3
3. Crave salt or salty things	0	1	2	3
4. Have multiple points on my body that when touched are tender or painful	0	1	2	3
5. Have dark circles under my eyes	0	1	2	3
6. Feel a sudden sense of anxiety when I get hungry	0	1	2	3
7. Use medications to manage pain	0	1	2	3
8. Get dizzy when rising or standing up from a kneeling or sitting position	0	1	2	3
9. Have diarrhoea or bouts of nausea with or without vomiting for no apparent reason	0	1	2	3
10. Have headaches	0	1	2	3

Combined Score of all Columns in Section C:

Section D:

1. Have trouble organising my thoughts	0	1	2	3
2. Get easily distracted and lose focus	0	1	2	3
3. Have difficulty making decisions and mistrust my judgment	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6. Am forgetful	0	1	2	3
7. Feel unsettled, restless, and anxious	0	1	2	3
8. Wake up tired and unrefreshed	0	1	2	3
9. Experience heartburn and indigestion	0	1	2	3
10. Catch colds or infections easily	0	1	2	3

Combined Score of all Columns in Section D:

Section E:

1. Feel tired for no apparent reason	0	1	2	3
2. Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3. Find it difficult to concentrate and complete tasks	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Feel cold or chilled - hands, feet, or all over - for no apparent reason	0	1	2	3
6. Have little or no interest in sex	0	1	2	3
7. Sweat spontaneously during the day	0	1	2	3
8. Feel puffy and retain fluids	0	1	2	3
9. Sleep more than nine hours a night	0	1	2	3
10. Have poor muscle tone	0	1	2	3
11. Have trouble losing weight	0	1	2	3
12. Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13. Have no energy and feel physically weak	0	1	2	3
14. Am susceptible to colds and the flu	0	1	2	3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Combined Score of all Columns in Section E: ______

Add points from sections A, B & C — Total for A, B & C: ________

Add points from sections C, D & E — Total for C, D & E: ________

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:

1 2 3 4 5 6 7 8 9 10

2. What do you consider to be the major causes of your stress (for example - spouse, family, friends, work, finances, wedding, pregnancy, legal, commute): ____

____

____

Where did you hear about the practice?

Please indicate:

- ☐ Internet search engine (please specify): ________________________
- ☐ Website (address used): ________________________
- ☐ Referred by (please name): ________________________
- ☐ Business card (received from/at): ________________________
- ☐ Other: (please name): ________________________

Medical Terms and Conditions

The terms and conditions set out below constitute the agreement concluded between this practice and the patient and main member of the applicable medical aid.

1. Medical Information / Medication

(a) I have disclosed all known allergies, medication and medical/health conditions in order for Dr. Herman Spies to evaluate my health requirements.
(b) I understand that medication prescribed must be used in accordance with the doctors' instructions. I shall immediately submit to and bring to the attention of Dr. Herman Spies any side-effects resulting from the consumption of any medication.
(c) I will strictly adhere to all warnings/instructions of medication recommended by Dr. Spies.

2. Payment (Private / Medical Aid)

(a) I have familiarised myself with the benefits and conditions of my medical aid scheme (especially those relating to referral restrictions, waiting periods, authorisation processes, maximum payments and or balances) prior to the consultation date.
(b) I further acknowledge that I have been informed that this is a private practice and its fees may exceed that allowed for by the medical aid scheme. (The cost of the services provided will be discussed with patients when making the appointment or during the consultation should I require any additional consultations/treatments.
(c) I agree to pay my account in full on the day of the consultation and/or treatment, either by Cheque, Cash, EFT or Credit Card. I understand that I will be held liable for any appointments made, that are not kept, unless the appointment has been cancelled at least 2 days in advance.
(d) I will be responsible for submitting any claim for consultations, services rendered or medicines received to my medical aid scheme.
(e) Treatment provided may require the hospitalisation of the patient and services of specialists which services are provided at an additional cost. I acknowledge that it is my responsibility to determine the cost of the services provided by the aforementioned bodies, to ensure that such services are covered by my medical aid scheme and obtain the necessary pre-authorisation for such services.
(f) Should I fail to pay the account in full on the day of the consultation, interest calculated at 2% per month may be added to the outstanding balance until such time as outstanding sum has been paid in full. Should the sum due still be outstanding after sixty (60) days after receipt of the account, legal action will be instigated for the recuperation of the costs for services rendered and I will be responsible for payment of any/all collection fees resulting from such action.
(g) I confirm that I have been advised that the practice reserves the right to impose a consultation fee of R534.65 per hour or a pro rata sum for any telephonic consultation relating to any new medical issue which I may experience.

3. Medical Certificates / Prescriptions

(a) It is the standard practice of the practice to hand medical certificates and prescriptions to the patient on date of the consultation. Should I require a copy or replacement of the certificate/prescription I may request same by:
    3.(a).i Collecting it in person; or
    3.(a).ii Request, in writing, that it is sent to my email or facsimile nominated on the PATIENT INFORMATION SHEET.
(b) Should I require the certificate to be collected by or sent to any third party, I acknowledge that I will furnish such authorization to the practice in writing.

4. Confidentiality

(a) All information furnished to the practice shall be treated as strictly confidential by the doctor and staff. The practice may be required to provide personal information to the following bodies:
    4.(a).i Medical Aid Schemes, who in turn may furnish the information to the principle member of the Medical aid Scheme;
    4.(a).ii Referring Doctors;
    4.(a).iii Consulting Specialists; and
    4.(a).iv Any further third parties if such sharing of information is pertinent to the treatment in question or relates to the payment thereof.

(b) The Children's Act provides that children from the age of 12 years may in instances consent to medical treatment. Information provided by such minors is confidential and may only be divulged with the minor child's consent.
(c) My consent is required in order for the doctor to investigate, treat or to perform procedure, which consent may be retracted prior to the provision of such medical care.
(d) The practice will not disclose my personal information to any party other than those listed herein unless required by law. It is therefore my responsibility to disclose my medical condition to my employer or any third party requesting such information.

5. Authority to Consent (if applicable)

(a) I am the guardian/parent/curator of the patient and legally authorised to consent to the treatment provided by the practice.__________(initial)
(b) I further acknowledge that I shall be liable for any account for services rendered by this practice to the aforementioned patient which may be due and payable.__________(initial)

6. Scope of Practice
(a) I understand that Dr Spies is practising as a Natural/Alternative health practitioner using, amongst others Homeopathic and Chinese herbal medicines (under the Allied Health Professions Council of SA). All statements therefore provided reflect a Homeopathic practice number and codes. Dr Spies can not be held responsible for any medicines or services not reimbursed by the relevant medical aid.
(b) I understand that Dr Spies is not practising as a GP (under the Health Professions Council of SA). If Dr Spies deems it more appropriate to consult as a GP in particular situations, he will first motivate why, and only after obtaining written consent, proceed in his capacity as a General Practitioner.

7. General

(a) I confirm that all information submitted by me is true and correct and I have the necessary authority to furnish the practise with any personal information herein contained.
(b) I further acknowledge that I have read and understand the terms and conditions herein contained and agree to be bound thereby.
(c) Nothing herein, seeks to derogate the practice's obligation in terms of any existing legislation and if any clause herein is found to be in contravention of such clause, it shall be deemed invalid.

Signed at ______________________________ on this the ______ day of ______________________________

____
Patient's Name

____
Patient's/Guardian's Signature

____
Main Member's Name

____
Main Member's Signature

____
For Practice: Name

____
Signature