|  |
| --- |
| **IMPORTANT NOTES**   * We recommend that you complete this health questionnaire on a computer if possible. * You will likely need to allow approximately two hours to fully complete this questionnaire, and we remind you to save the document regularly as you proceed. * Please answer all of the questions as best you can. * If for some reason you are unable to complete the whole questionnaire, please ensure you at least complete the ‘General Information’ section and the ‘Current Medications, Supplements and Therapies’ section. * When you have completed the questionnaire, please email it to [info@drjanellesinclair.com](mailto:info@drjanellesinclair.com). * In order to get the most out of your consultation with Dr Janelle, please endeavour to submit your completed questionnaire to Dr Janelle at least two days before your consultation. |

# GENERAL INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Today’s date:** |  | | | | |
| 1. **Your personal details** | | | | | |
| Name: |  | | | | |
| Date of birth: |  | | Gender: |  | |
| Height: |  | | Weight: |  | |
| Address: |  | | | | |
| Phone: |  | | | | |
| Email: |  | | | | |
| 1. **Emergency contact** | | | | | |
| Name: |  | | | | |
| Address: |  | | | | |
| Phone: |  | | | | |
| 1. **What do you hope to achieve in your visit with Janelle?** | | | | | |
|  | | | | | |
| 1. **Please list current and on-going problems in order of priority:** | | | | | |
| **Symptom:** | | **Delete those that don’t apply:** | | | **Date of onset:** |
|  | | Mild / Moderate / Severe | | |  |
|  | | Mild / Moderate / Severe | | |  |
|  | | Mild / Moderate / Severe | | |  |
|  | | Mild / Moderate / Severe | | |  |
|  | | Mild / Moderate / Severe | | |  |
| 1. **When was the last time you felt well?** | | | | | |
|  | | | | | |
| 1. **Did something trigger your change in health?** | | | | | |
|  | | | | | |
| 1. **What makes you feel worse?** | | | | | |
|  | | | | | |
| 1. **What makes you feel better?** | | | | | |
|  | | | | | |
| 1. **What diagnoses or explanations have been given in the past?** | | | | | |
|  | | | | | |

# MEDICAL HISTORY

## CONDITIONS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **For each of the conditions below which apply to you, please provide the date of onset and specify**   **(Y or N) if it is ongoing (leave blank any that don’t apply)** | | | | | |
| **Onset** | **Ongoing?** | ***GASTROINTESTINAL*** | **Onset** | **Ongoing?** | ***INFLAMMATORY/AUTOIMMUNE*** |
|  |  | Irritable bowel syndrome |  |  | Chronic fatigue syndrome |
|  |  | Inflammatory bowel disease |  |  | Autoimmune disease |
|  |  | Crohn’s disease |  |  | Rheumatoid arthritis |
|  |  | Ulcerative colitis |  |  | Lupus SLE |
|  |  | Gastritis or peptic ulcer disease |  |  | Frequent infections |
|  |  | GERD (reflux) |  |  | Food allergies |
|  |  | Coeliac disease |  |  | Multiple chemical sensitivities |
| **Onset** | **Ongoing?** | ***CARDIOVASCULAR*** | **Onset** | **Ongoing?** | ***RESPIRATORY DISEASES*** |
|  |  | Heart attack |  |  | Asthma |
|  |  | Stroke |  |  | Chronic sinusitis |
|  |  | Elevated cholesterol |  |  | Bronchitis |
|  |  | Arrhythmia (irregular heart rate) |  |  | Sleep apnoea |
|  |  | Hypertension (high blood pressure) | **Onset** | **Ongoing?** | ***SKIN DISEASES*** |
|  |  | Other heart disease |  |  | Eczema |
| **Onset** | **Ongoing?** | ***METABOLIC/ENDOCRINE*** |  |  | Psoriasis |
|  |  | Type 1 diabetes |  |  | Acne |
|  |  | Type 2 diabetes | **Onset** | **Ongoing?** | ***NEUROLOGIC/MOOD*** |
|  |  | Hypoglycaemia |  |  | Depression |
|  |  | Insulin resistance or pre-diabetes |  |  | Anxiety |
|  |  | Hypothyroidism (low thyroid) |  |  | Bipolar disorder |
|  |  | Hyperthyroidism (overactive thyroid) |  |  | Schizophrenia |
|  |  | Polycystic ovarian syndrome (PCOS) |  |  | Headaches or migraines |
|  |  | Infertility |  |  | ADD/ADHD |
|  |  | Weight gain |  |  | Autism |
|  |  | Weight loss |  |  | Memory problems |
|  |  | Bulimia or anorexia |  |  | Parkinson’s disease |
|  |  | Binge eating |  |  | Multiple sclerosis |
| **Onset** | **Ongoing?** | ***CANCER*** |  |  | ALS |
|  |  | Lung |  |  | Seizures |
|  |  | Breast |  |  | Head injury |
|  |  | Colon | **Onset** | **Ongoing?** | ***MUSCULOSKELETAL/PAIN*** |
|  |  | Ovarian |  |  | Osteoarthritis |
|  |  | Prostate |  |  | Fibromyalgia |
|  |  | Skin |  |  | Chronic pain syndrome |
| **Onset** | **Ongoing?** | ***GENITAL AND URINARY SYSTEMS*** | **Onset** | **Ongoing?** | ***PLEASE LIST ANY OTHER CONDITIONS*** |
|  |  | Kidney disease |  |  |  |
|  |  | Gout |  |  |  |
|  |  | Frequent urinary tract infections |  |  |  |
|  |  | Frequent yeast infections |  |  |  |
|  |  | Erectile or sexual dysfunction |  |  |  |

## SURGERIES

|  |  |
| --- | --- |
| 1. **Please provide the date of any significant surgeries that apply to you. Eg. appendectomy, hysterectomy, gallbladder, hernia, tonsillectomy, joint replacement, heart surgery, pacemaker, breast implant, other.** | |
| **Surgery performed** | **Date of surgery** |
|  |  |
|  |  |

## FOR WOMEN ONLY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Obstetrics History** | | | | |
| 1. **Are you currently pregnant?** | |  | | |
| 1. **Are you currently breastfeeding?** | |  | | |
| 1. **Please indicate HOW MANY of each of the following apply to you:** | | | | |
|  | Pregnancies | |  | Miscarriage |
|  | Gestational diabetes | |  | Abortion |
|  | Postpartum depression | |  | Living children |
| **Menstrual History** | | | | |
| 1. **Age at first period:** | | | |  |
| 1. **Menses frequency:** | | | |  |
| 1. **Menses length:** | | | |  |
| 1. **Date of last menstrual period:** | | | |  |
| 1. **Do you experience pain and/or clotting?** | | | |  |
| 1. **Do you experience premenstrual syndrome (PMS) or have increased irritability, anxiety, mood swings, or depression the week or two before your period?** | | | |  |
| 1. **Has your period ever skipped? If yes, for how long?** | | | |  |
| 1. **Do you currently use hormonal contraception?** | | | |  |
| 1. **If yes, how long have you been using it?** | | | |  |
| 1. **If no, have you used hormonal contraception in the past?** | | | |  |
| 1. **If yes to either of the above, does/did it agree with you?** | | | |  |
| **Women’s Disorders / Hormonal Imbalances** | | | | |
| 1. **Please indicate Y or N if you are currently or have previously suffered any of the following conditions:** | | | | |
|  | Fibrocystic breasts | |  | Painful periods |
|  | Endometriosis | |  | Heavy periods |
|  | Fibroids | |  | PMS |
|  | Infertility | |  |  |
| 1. **Has menopause started for you?** | | |  | |
| 1. **If yes, what age did menopause start?** | | |  | |
| 1. **Please indicate which menopausal symptoms you are currently experiencing:** | | | | |
|  | Hot flashes | |  | Joint pain |
|  | Mood swings | |  | Headaches |
|  | Concentration/memory problems | |  | Weight gain |
|  | Vaginal dryness | |  | Loss of control of urine |
|  | Decreased sex drive | |  | Heavy bleeding |
| 1. **Are you using hormone replacement therapy? If yes, how long have you been using it?** | | | |  |

# CURRENT MEDICATIONS, SUPPLEMENTS AND THERAPIES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Allergies to medications & supplements** | | | | | |
| **Medication / Supplement** | | | **Reaction** | | |
|  | | |  | | |
|  | | |  | | |
|  | | |  | | |
|  | | |  | | |
| 1. **Current medications** | | | | | |
| **Medications** | **Dose** | **Frequency** | | **Start date** | **Reason for use** |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
| 1. **Current supplements** | | | | | |
| **Supplement** | **Dose** | **Frequency** | | **Start date** | **Reason for use** |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
| **Other current therapies/counselling/treatments** | | | | | |
| **Therapy or treatment** | | | **Reason for use/ details** | | |
|  | | |  | | |
|  | | |  | | |

# PAST MEDICATIONS, SUPPLEMENTS AND THERAPIES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Past medications trialled** | | | | | |
| **Medications** | **Dose** | **Frequency** | **How long did you take it?** | | **Was it beneficial?** |
|  |  |  |  | |  |
|  |  |  |  | |  |
|  |  |  |  | |  |
|  |  |  |  | |  |
| 1. **Past supplements or dietstrialled** | | | | | |
| **Supplement or diet** | **Dose** | **Frequency** | **How long did you take it?** | | **Was it beneficial?** |
|  |  |  |  | |  |
|  |  |  |  | |  |
|  |  |  |  | |  |
|  |  |  |  | |  |
| 1. **Other past therapies/counselling/treatments trialled** | | | | | |
| **Therapy or treatment** | | **Details:** | | | **Was it beneficial?** |
|  | |  | | |  |
|  | |  | | |  |
|  | |  | | |  |
|  | |  | | |  |
| 1. **Have your medications or supplements ever caused you unusual side effects or problems? Please describe:** | | | | | |
|  | | | | | |
| 1. **Have you ever had to take antibiotics quite frequently? (i.e. more than 3 times per year). If yes, when?** | | | |  | |
| 1. **Have you ever had to take long-term antibiotics?** | | | |  | |

# FAMILY HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| **Please consider the following questions before you start:**   * Are there any health conditions and diseases that are present in the family health history? * What health conditions and diseases do your family members (blood relatives) suffer from? * What health conditions did family members who are no longer alive, suffer from? * What physical characteristics are common in your family? | | | |
| 1. **Please indicate Y for each of the conditions that affects someone in your family and who it affects:** | | | |
| **Y** | **Symptoms & health problems in the family** | **Which relative did this affect?** | **What it could mean:** |
|  | Vitiligo |  | If these signs and/or  health conditions run in  your family, the common  underlying cause may be  **Coeliac disease** |
|  | Prematurely grey hair or early baldness |  |
|  | Arthritis |  |
|  | Bowel cancer |  |
|  | Pernicious anaemia |  |
|  | Thyroid disorders |  |
|  | Coeliac disease |  |
|  | Autoimmune conditions |  |
|  | Chronic indigestion |  |
|  | Frequent diarrhoea |  |
|  | Lack of energy |  |
|  | Pellagra (vitamin B3 deficiency) |  |
|  | Dementia |  |
|  | Frequent colds |  | If these signs and/or  health conditions run in  your family, the common  underlying cause may be  **Food allergies or**  **sensitivities** |
|  | Sore throats or swollen glands |  |
|  | Ear infections |  |
|  | Coughs |  |
|  | Asthma |  |
|  | Hay fever |  |
|  | Eczema |  |
|  | Hives |  |
|  | Postnasal drip |  |
|  | Known food allergies or sensitivities |  |
|  | Schizo-affective disorders |  | If these signs and/or health conditions run in  your family, the common  underlying cause may be  **The ‘Mauve Factor’ (pyroluria)** |
|  | Frequent miscarriages |  |
|  | High inner tension |  |
|  | An inability to tolerate stress |  |
|  | Dyslexia |  |
|  | Alcoholism or addictions |  |
|  | Autism |  |
|  | Delayed puberty |  |
|  | Morning nausea |  |
|  | Infertility (in both men & women) |  |
|  | Stretch marks |  |
|  | White spots in finger nails |  |
|  | Pale skin |  |
|  | Addictions |  | If these signs and/or health conditions run in your family, the common underlying cause may be  **Methylation imbalances** |
|  | Obsessive compulsive disorder |  |
|  | Infertility (in both men & women) |  |
|  | Seasonal allergies |  |
|  | Migraine headaches |  |
|  | High sex drive |  |
|  | Fast metabolism |  |
|  | Highly motivated and energetic |  |
|  | Large ears and long fingers and toes |  |

# SOCIAL HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| **Psycho-social** | | | |
| **Please indicate Y or N for each of the questions below:** | | | |
| 1. **Do you feel significantly less vital than you did a year ago?** | | |  |
| 1. **Do you feel your life has meaning and purpose?** | | |  |
| 1. **Do you believe stress is presently reducing the quality of your life?** | | |  |
| 1. **Do you like the work you do?** | | |  |
| 1. **Do you spend the majority of your time and money to fulfil responsibilities and obligations?** | | |  |
| 1. **Have you or your family recently experienced any major life changes? If yes, please describe below:** | | |  |
|  | | | |
| 1. **Have you experienced any major losses in life? If yes, please describe below:** | | |  |
|  | | | |
| 1. **How important is God, religion (or spirituality) for you and your family’s life? (**Delete two answers alongside that don’t apply). Please explain further below: | | | Not at all important Somewhat important Extremely important |
|  | | | |
| 1. **How much time have you lost from work or school in the past year? (**Delete two answers alongside that don’t apply) | | | 0-2 days  3 –14 days  More than 15 days |
| **Trauma**  Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction. Witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is an issue still in your life now, it is very important that you feel safe telling us about it, so that we can support you and optimise your treatment outcomes.  We understand that some of these questions may be difficult to answer, but ask that you please do your best to answer as many as possible: | | | |
| **Please indicate Y or N for each of the questions below:** | | | |
| 1. **Did you feel safe growing up?** | | |  |
| 1. **Have you been involved in abusive relationships in your life?** | | |  |
| 1. **Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?** | | |  |
| 1. **Do you currently feel safe in your home?** | | |  |
| 1. **Do you feel safe, respected and valued in your current relationship?** | | |  |
| 1. **Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? If yes:**    * When?    * Please briefly describe below: | | |  |
|  | | | |
| 1. **Are you comfortable / able to discuss this event briefly during the consultation?** | | |  |
| 1. **Have you in the past or are you currently receiving counselling or therapy for these issues? If yes, please describe below:** | | |  |
|  | | | |
| **Stress & Coping** | | | |
| **Please indicate Y or N for each of the questions below:** | | | |
| 1. **Do you feel you have an excessive amount of stress in your life?** | | |  |
| 1. **Do you feel you can easily handle the stress in your life?** | | |  |
| 1. **Do you pray or practice meditation or relaxation technique? If yes, how often?** | | |  |
| 1. **Rate each of the following daily stressors on scale of 1-10**   **(1=no stress; 10=excessive stress):** | | |  |
| * + **Work** |  | * **Finances** |  |
| * + **Family** |  | * **Health** |  |
| * + **Social** |  | * **Other** |  |
| **Sleep & Rest** | | | |
| 1. **Average number of hours you sleep per night: (**Delete the answers alongside that don’t apply) | | | More than 10 hours  8-10 hours  6-8 hours  Less than 6 |
| **Please indicate Y or N for each of the questions below:** | | | |
| 1. **Do you have trouble falling asleep?** | | |  |
| 1. **Do you feel rested upon awakening?** | | |  |
| 1. **Do you have problems staying asleep?** | | |  |
| 1. **Do you do shift work or have you in the past?** | | |  |
| 1. **Do you use sleeping aids? If yes, please describe below:** | | |  |
|  | | | |

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9) (A DEPRESSION SCALE)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Please indicate Y in the column that best reflects how often you have been bothered by the following problems during the last 2 weeks:** | | | | |
| **Symptoms** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |
| Trouble falling or staying asleep, or sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or overeating |  |  |  |  |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| Moving or speaking so slowly that other people might have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual |  |  |  |  |
| Thoughts of hurting yourself or that you would be better off dead |  |  |  |  |
| **Please count the number of Y answers in each column** |  |  |  |  |
| **TOTAL SCORE (To be completed by Dr Janelle)** |  | | | |

# PATIENT HEALTH QUESTIONNAIRE (GAD-7)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Please indicate Y in the column that best reflects how often you have been bothered by the following problems during the last 2 weeks:** | | | | |
| **Symptoms** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| Feeling nervous, anxious, or on edge |  |  |  |  |
| Not being able to stop or control worrying |  |  |  |  |
| Worrying too much about different things |  |  |  |  |
| Trouble relaxing |  |  |  |  |
| Being so restless that it's hard to sit still |  |  |  |  |
| Becoming easily annoyed or irritable |  |  |  |  |
| Feeling afraid as if something awful might happen |  |  |  |  |
| **Please count the number of Y answers in each column** |  |  |  |  |
| **TOTAL SCORE (To be completed by Dr Janelle)** |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Symptoms** | | | |
| 1. **Please indicate Y for each of the symptoms below that you are currently experiencing:** | | | |
|  | **General** |  | **Skin** |
|  | Cold hands and feet |  | Itchy skin |
|  | Cold intolerance |  | Dry skin |
|  | Low body temperature |  | Dry scalp/ dandruff |
|  | Low blood pressure |  | **Lymph Nodes** |
|  | Difficulty falling asleep |  | Enlarged/neck |
|  | Early waking |  | Tender/neck |
|  | Night waking |  | Other enlarged/tender lymph nodes |
|  | Nightmares |  | **Nails** |
|  | Poor dream recall |  | Bitten |
|  | Fatigue |  | Brittle |
|  | Hearing blood pulsing in head on pillow at night |  | Fungus - toes |
|  | Frequent coldsores |  | Ridges |
|  | **Head, Eyes & Ears** |  | White spots/lines |
|  | Cracks behind ears |  | **Respiratory** |
|  | Distorted sense of smell |  | Allergies |
|  | Distorted taste |  | Bad breath |
|  | Ear wax (lots, oozing) |  | Sore throat |
|  | Fissure (crack/groove) down middle of tongue |  | Hay fever |
|  | Hearing loss |  | Nasal stuffiness |
|  | Headache or migraine |  | Post nasal drip |
|  | Many dental fillings/ poor dental enamel |  | Sinus infection |
|  | None or few dental fillings |  | Snoring |
|  | Mouth ulcers |  | Wheezing |
|  | Premature greying of hair |  | **Cardiovascular** |
|  | Sensitivity to loud noises |  | Angina/chest pain |
|  | Vision problems (other than glasses) |  | Heart murmur or palpitations |
|  | Macular degeneration |  | Swollen ankles/feet |
|  | Excessive saliva |  | **Urinary** |
|  | **Mood/ Nerves** |  | Bed wetting |
|  | Anxiety |  | Kidney disease |
|  | Auditory or visual hallucinations |  | Urinary Infection |
|  | Depression |  | **Male Reproductive** |
|  | Difficulty concentrating |  | Impotence |
|  | Difficulty with balance |  | Enlarged prostate |
|  | Dizziness (spinning) or Light-headedness |  | Low sex drive |
|  | Fainting |  | High sex drive |
|  | Irritability |  | **Female Reproductive** |
|  | Phobias |  | Breast cysts or lumps |
|  | Panic attacks |  | Breast tenderness |
|  | Paranoia |  | High sex drive |
|  | Seizures |  | Low sex drive |
|  | Tingling hands and/or feet |  | Ovarian cyst |
|  | Tremor/trembling |  | Vaginal itch |
|  | **Digestion** |  | Vaginal pain with sex |
|  | Abdominal pain |  | Heavy or painful periods |
|  | Bloating of abdomen |  | Irregular periods |
|  | Bloating after meals |  | None or scanty periods |
|  | Blood in stools |  | **Female: Premenstrual (before your period)** |
|  | Burping |  | Bloating |
|  | Canker sores (mouth ulcers) |  | Breast tenderness |
|  | Constipation |  | Cravings |
|  | Cracking at corner of lips |  | Constipation or diarrhoea |
|  | Diarrhoea |  | Decreased or increased sleep |
|  | Alternating diarrhoea and constipation |  | Fatigue |
|  | Excess flatulence/gas |  | Irritability |
|  | Foods ‘repeat’ (reflux) |  | **Skin Problems** |
|  | Haemorrhoids |  | Acne |
|  | Indigestion |  | Athlete’s foot |
|  | Nausea |  | Broken capillaries on face |
|  | Intolerance to lactose and/or dairy products |  | Bumps on back of upper arms |
|  | Intolerance to wheat |  | Butterfly rash on face |
|  | Intolerance to gluten (wheat, rye, barley) |  | Cellulite |
|  | Intolerance to eggs |  | Dark circles under eyes |
|  | Intolerance to fatty foods |  | Ears get red |
|  | Intolerance to yeast |  | Easy bruising |
|  | Abnormal liver function tests |  | Lack of sweating |
|  | Mucus in stools |  | Eczema |
|  | Sore tongue |  | Hair loss |
|  | Strong stool odour |  | Hives |
|  | Undigested food in stools |  | Jock itch |
|  | **Eating** |  | Pale skin |
|  | Can’t maintain healthy weight |  | Rash |
|  | Poor appetite |  | Red face |
|  | Morning nausea (don’t like eating breakfast) |  | Sensitive to Bites |
|  | Salt cravings |  | Shingles |
|  | Carbohydrate or sugar cravings |  | Skin darkening |
|  | Caffeine dependent |  | Sweet body odour |
|  | **Musculoskeletal** |  | Stretch marks |
|  | Frequent Muscle spasms |  | Thin skin, breaks easily |
|  | Frequent Muscle cramping |  | Vitiligo |
|  | Joint pain or stiffness |  | Wrinkles above the top lip |
|  | Muscle pain or weakness |  |  |
|  | Muscle twitches around eyes |  |  |
|  | Muscle weakness |  |  |

# READINESS ASSESSMENT

|  |  |
| --- | --- |
| 1. **On a scale of 1 to 10, how willing are you to do the following in order to improve your health?**   (1=no motivation; 10=high motivation) | |
| * + **Significantly modify your diet** |  |
| * + **Take several nutritional supplements each day** |  |
| * + **Keep a record of everything you eat each day** |  |
| * + **Modify your lifestyle (e.g. work demands, sleep habits)** |  |
| * + **Practice a relaxation technique** |  |
| * + **Engage in regular exercise** |  |
| * + **Have periodic lab tests to assess your progress** |  |
| 1. **How confident are you of your ability to organise and follow through on the above health related activities?** |  |
| 1. **Do you have any comments you would like to add?** | |
|  | |

# INFORMED CONSENT FOR CLIENT’S OF DR JANELLE SINCLAIR

## ANTIDEPRESSANT & ANTIPSYCHOTIC MEDICATIONS

The treatment options that may be recommended during a consult with Dr Janelle Sinclair (PhD Biochemistry) are normally safe to use alongside antidepressant and antipsychotic medication, unless otherwise stated. In fact, the biochemical imbalances that are investigated by Janelle are often seen in people that only have a partial response to medications. Therefore, if you are presently on antidepressant or antipsychotic medications you should not stop using them before seeing Janelle.

If reducing your medication is an aim for you, we advise that you only do this once you have:

1. Seen Janelle and implemented her strategies AND
2. Seen improvements in your mood AND
3. Achieved long-term stability. Furthermore, this should only be done under consultation and with the guidance of your medical practitioner.

## NUTRITIONAL AND HERBAL SUPPLEMENTS

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term drug is defined as an “article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.” Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally.

In this office, we provide nutritional counselling and make individualised recommendations regarding use of these substances in order to upgrade the quality of foods in a patient’s diet and to supply nutrition to support the physiological and biomechanical processes of the human body.

Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

## PSYCHOLOGICAL & CRISIS/EMERGENCY CARE

Your wellbeing is important to us. The services provided by Janelle have the purpose of investigating and treating the physical imbalances that contribute to depression and/or other mental health conditions. These services in no way should be construed as psychological counselling or any type of psychotherapy.

If you do not currently see a counsellor, psychiatrist, or psychologist we advise that you seek adequate emotional support. Otherwise we want to bring the available services to your attention; a list of helplines and emergency services in New Zealand are provided for your information and wellbeing. If you have concerns about these issues, please discuss them with Janelle.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

have read and understand the above statements on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) and seen the list of helpline and emergency services in New Zealand below.

## HELPLINES & EMERGENCY MENTAL HEALTH CONTACT DETAILS

### Depression Helpline

0800 111 757

Available 8am to midnight

### Lifeline

0800 543 354

www.lifeline.org.nz

A 24 hour service

### Mental Health Emergency Contact Numbers

This list is not exhaustive, so please refer to your local telephone book if your area is not listed below.

**Auckland**

* Central Auckland: 0800 800 717
* West Swanson, Piha & Titirangi: 09 822 8500
* Henderson: 09 822 8600
* North Shore / East Rodney - ask for the CATT team North: 09 486 1491
* South Auckland: 09 270 4742

**Waikato**

Covers Coromandel, Hamilton to National Park

0800 505 050

**Wellington**

Covers Wellington, Kapiti Coast, Porirua City, Wellington City, Upper Hutt, Lower Hutt region

(04) 494 9169

**Christchurch**

0800 920 092

03 364 0482

**Dunedin**

For out of hours emergencies, phone Dunedin Hospital 03 474 0999 and ask for the Emergency Psychiatric Service. They will contact the Central Otago on-call worker.

### Emergency Advice

For advice in emergencies, you can contact mental health services as follows:

* Search White Pages online [www.whitepages.co.nz](http://www.whitepages.co.nz)
* White Pages printed telephone directory:
  + Turn to the last, green-striped section at the front of the book, entitled 'Hospital and other Health Service providers'.
  + In that section, look for a listing for the local hospital or District Health Board and locate 'Mental Health Services' or, in some cases, 'Psychiatric Services' and phone that number to ask for advice.
  + In some areas there may be a listing for CATT (Community Assessment and Treatment Team) or a Crisis Assessment Team. If so, phone the appropriate number.
  + If there is no response (after hours), phone the hospital 'Mental Health' number or the main number for the hospital for advice.