

DATE \_\_\_\_\_ PATIENT FULL NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE: H \_\_\_\_\_ W \_\_\_\_\_ M \_\_\_\_\_

EMAIL \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ CHILDREN \_\_\_\_\_

OCCUPATION/RETIRED \_\_\_\_\_ DO YOU ENJOY YOUR WORK \_\_\_\_\_

REASON FOR  
CONSULTATION/TREATMENT \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOW ARE YOU FEELING TODAY \_\_\_\_\_

ARE YOU RECEIVING ANY OTHER THERAPIES \_\_\_\_\_

PHYSICIANS NAME \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CONSENT REQUIRED \_\_\_\_\_

### **MEDICAL HISTORY**

HAVE YOU SUFFERED FROM MEDICAL CONDITIONS OF?

Heart \_\_\_\_\_ Liver \_\_\_\_\_ Kidneys \_\_\_\_\_ Pancreas \_\_\_\_\_

Thyroid \_\_\_\_\_ Nervous System \_\_\_\_\_ Stomach \_\_\_\_\_

Bowels \_\_\_\_\_ Lungs \_\_\_\_\_ Other \_\_\_\_\_

Back/Spine/Joints \_\_\_\_\_

Operations \_\_\_\_\_

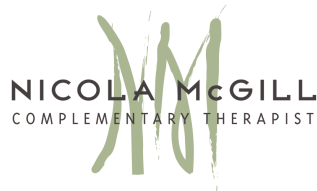
Accidents \_\_\_\_\_ Areas Affected \_\_\_\_\_

Current Medication \_\_\_\_\_ Past Medications \_\_\_\_\_ Dates \_\_\_\_\_

Allergies: Skin \_\_\_\_\_ Respiratory \_\_\_\_\_ Food \_\_\_\_\_

Details of Allergies: Triggers/ Coping Mechanisms/ Medications \_\_\_\_\_

\_\_\_\_\_



**SYSTEM ASSESSMENTS**

**DIGESTIVE:**

Appetite: Good \_\_\_\_\_ Poor \_\_\_\_\_ Meals: Regular \_\_\_\_\_ Irregular \_\_\_\_\_

Digestion: Good \_\_\_\_\_ Heartburn/acid reflux \_\_\_\_\_ Bloating \_\_\_\_\_ Other \_\_\_\_\_

Typical Daily Diet: Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Mid Afternoon \_\_\_\_\_

Evening \_\_\_\_\_

Coffee/Tea \_\_\_\_\_ Alcohol \_\_\_\_\_

Daily Bowel Movements: \_\_\_\_\_ Constipation \_\_\_\_\_ Diarrhoea \_\_\_\_\_ Pain \_\_\_\_\_

Alternating \_\_\_\_\_ Bloating \_\_\_\_\_

**URINARY:**

Cystitis/Prostrate \_\_\_\_\_ Discomfort \_\_\_\_\_

**RESPIRATORY:**

Asthma \_\_\_\_\_ Sinus \_\_\_\_\_ Ears \_\_\_\_\_

**LYMPHATIC:**

Swollen Glands/ Sore Throats/ Swollen Ankles/Frequent Colds \_\_\_\_\_

**CIRCULATION:**

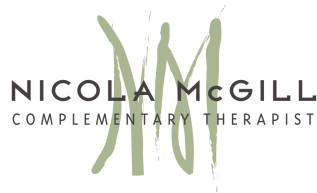
Good \_\_\_\_\_ Poor \_\_\_\_\_ Cold/Warm \_\_\_\_\_ Varicose Veins \_\_\_\_\_

Hypertension \_\_\_\_\_ Hypotension \_\_\_\_\_ Other \_\_\_\_\_

**SKIN:**

Normal \_\_\_\_\_ Dry \_\_\_\_\_ Sensitive \_\_\_\_\_ Oily \_\_\_\_\_ Combination \_\_\_\_\_

Eczema \_\_\_\_\_ Psoriasis \_\_\_\_\_ Other \_\_\_\_\_



MUSCULAR/SKELETAL:

Injuries \_\_\_\_\_ Stiffness \_\_\_\_\_  
Pain \_\_\_\_\_ Other \_\_\_\_\_

REPRODUCTIVE:

Female: Menstrual Cycle – Regular/Irregular \_\_\_\_\_ Next Due Date \_\_\_\_\_  
PMT \_\_\_\_\_ Dysmenorrhoea \_\_\_\_\_ Amenorrhoea \_\_\_\_\_  
Menopausal Difficulties \_\_\_\_\_ Hot Flashes \_\_\_\_\_  
Other \_\_\_\_\_  
Male: Prostate \_\_\_\_\_ Impotence \_\_\_\_\_ Other \_\_\_\_\_

NERVOUS :

Headaches \_\_\_\_\_ Epilepsy \_\_\_\_\_ Depression/Anxiety \_\_\_\_\_  
Sleep Pattern \_\_\_\_\_ Stress Levels ( 1-10) \_\_\_\_\_  
Stressors \_\_\_\_\_ Energy Levels- Good \_\_\_\_\_ Poor \_\_\_\_\_ Erratic \_\_\_\_\_ Fatigue \_\_\_\_\_

LIFESTYLE:

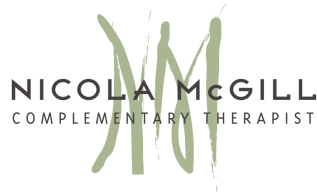
Weekly Exercise \_\_\_\_\_  
Time Out/ Personal recreation/Relaxation \_\_\_\_\_  
Do You Smoke \_\_\_\_\_ Are you around people that smoke \_\_\_\_\_

ASSESSMENT:

Posture – Lordosis/Scoliosis/Kyphosis \_\_\_\_\_  
Skin Colour/Texture \_\_\_\_\_ Circulation \_\_\_\_\_  
Constitutional Type \_\_\_\_\_  
Reflex Zones \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADDITIONAL NOTES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Consent Form

This is a Holistic Complementary Therapy Clinic and the treatments given are not taking the place of Conventional medicine. You will be advised to seek medical attention when needed

Every effort is made to encourage patients to give full details of any other treatment they have received or are receiving from whatever direction.

Whilst my aim is to always work for your benefit and to liaise wherever possible with other Practitioners/ Physicians tending to you, I ask you to accept, by signing this form, that I cannot give any guarantee of success or accept any liability in my sincere attempts to alleviate pain and /or secure for you a better way of life.

Also, by signing this form, you agree that you have read the foregoing notes and confirm that they are a true record. You have not withheld any information which might affect the course of your treatment and you undertake to keep your therapist Informed of any changes in your health and in any prescribed or self-administered medication in order to facilitate an update of this record, when necessary. The information you have given is strictly Private and Confidential.

Signature.....

Date.....