PATIENT HISTORY

CONFIDENTIAL

Patient Name: Mr ❑ Mrs. ❑ Miss ❑ ..... Date: .....

Address: .....

Address: ..... Postcode: .....

Phone: BH..... AH..... Mobile: .....

Occupation/Profession: .....

Email Address: ..... Birthdate: ..... Sex M ❑ / F ❑

This is my first visit to a Natural Therapist Yes ❑ / No ❑ No. of Children: .....

I have been recommended to this clinic by.....

MAIN HEALTH CONCERN:

Please encircle affected areas

Exact description of symptoms: .....

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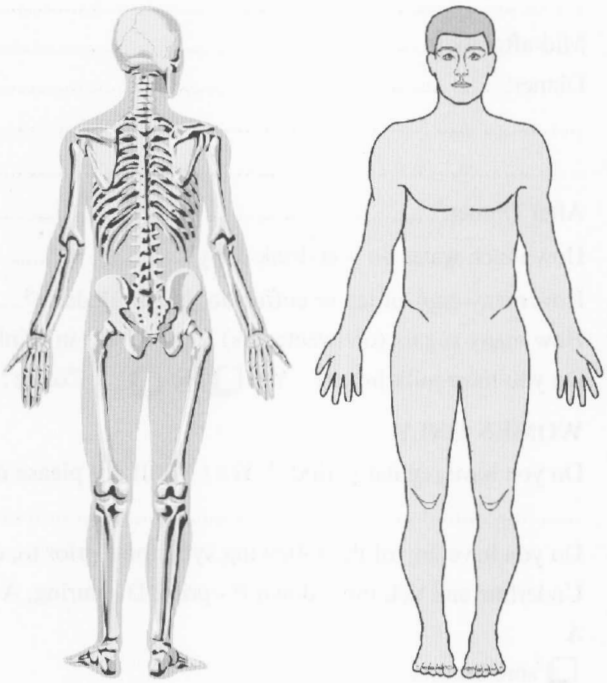

Previous Medical Care For Chief Complaint

Name and location of Doctor or Natural Therapist

.....Date: .....

Condition or Diagnosis: .....

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Type of Treatment: .....

Duration of Treatment: .....

Results of Treatment: Good ❑ Fair ❑ Poor ❑

Blood tests / X-rays / Scans / Other: .....

Date: .....

PAST HISTORY

List all surgery you have had and what age in life: .....

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List any past severe illness: .....

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Previous injuries / accidents, falls etc: .....

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Are you aware of any serious illness / condition existing at the present time? Yes ❑ No ❑

If yes, please describe: .....

HABITS, DRUGS AND SUPPLEMENTS

Sleep: How many hours nightly?..... I retire at: .....

Do you exercise? Daily ❑ Twice or more ❑ Weekly ❑ Never ❑

If applicable: What sort of exercise do you do? .....

Do you participate in any sports?.....

Do you smoke? Yes ❑ No ❑ How many per day?..... How long have you smoked? .....

Do you drink alcohol? Yes ❑ No ❑ How many times a week? .....

What drugs are you presently taking? (include dosage) and for what condition: .....

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What vitamins or mineral supplements are you taking? (include brand name and dosage) .....

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How often do you have a bowel motion? .....

Do you have any allergies? .....

Do you have headaches - if so how often? .....

How long have you been having them? .....

Do you have any back, neck or other body pain? Please describe: .....

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DIET

Please list what you eat and drink during your normal daily routine:

Arising: .....

Breakfast: .....

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Mid-morning: .....

Lunch: .....

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Mid-afternoon: .....

Dinner: .....

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After Dinner: .....

How much water do you drink daily?: .....

How many cups of tea or coffee do you drink daily? .....

How many sugars (or sweeteners) do you have in drinks? .....

Do you have milk in tea? Yes ❑ No ❑ Coffee? Yes ❑ No ❑

WOMEN ONLY

Do you have regular periods? Yes / No If not please describe: .....

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Do you have any of the following symptoms prior to, during or after your period?

Underline and tick (note down P - prior, D - during, A - after)

A

- ❑ sore breasts
- ❑ fluid retention
- ❑ PMT
- ❑ fatigue
- ❑ food cravings (if so what?.....)
- ❑ mid cycle bleeding
- ❑ wind / bloating

B

- ❑ abdominal cramping / aching
- ❑ backache
- ❑ nausea / vomiting
- ❑ headaches
- ❑ constipation / diarrhoea
- ❑ skin problems
- ❑ heavy clotting
- ❑ unusual discharge
- ❑ infections

Are you currently using contraception? If so, what type and how long? .....

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OTHER

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