

FULL NAME:	D.O.B:
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TITLE: (please circle)	Dr / Mr / Mrs / Ms / Miss	DATE:
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ADDRESS:	Post Code:
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MARITAL STATUS:

TEL. NO. Home:	Work:
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Mobile No:	OCCUPATION:
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G.P's NAME:

G.P's ADDRESS:

No. of Children:	Miscarriages:	Abortions:
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Are you pregnant:	YES / NO	How many weeks?
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N.B. You cannot have treatments when pregnant!

Are you presently seeing your doctor:	YES / NO	Why?
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List medications:

List all <u>past</u> medical problems giving approximate dates:

List all <u>past</u> surgical procedures with approximate dates:
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Would you consider the amount of antibiotics you have taken in the past to be: (Tick one only)	Higher than average?
Lower than average?	Average?

Are you seeing any other practitioners/therapists at present?	YES / NO
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Please list them and give a brief description of treatment received:
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Please list any vitamin and mineral supplements used
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Please list any herbs and/or homoeopathic remedies used:
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Please underline any of the following which affect you:	High blood pressure Heart problems Renal problems (kidney/bladder) An abdominal hernia Haemorrhoids Cirrhosis (of the liver)
Do you smoke: YES / NO	How many per day?
Do you drink: YES / NO	How much?
Do you eat food containing sugar: YES / NO	What? How often?
Do you drink tea: YES / NO	How cups per day?
Do you drink coffee: YES / NO	How cups per day?
Do you exercise: YES / NO	How often?
Approximately how often do you have your bowels open?	
Please describe the usual colour and consistency.	
Do you regularly use medication/herbs to create a bowel movement?	YES / NO
Have you been fitted with a pacemaker?	YES / NO
Have you any implanted organs?	YES / NO
Have you had an epileptic fit?	YES / NO
Do you have a family history of any of the following conditions? Please state how the sufferer was related to you and if possible what.	
Crohn's disease/ulcerative colitis	
Heart disease	
Cancer	
Diabetes	
Any other condition which may be relevant	

Please tick any of the symptoms listed below you may have suffered from.

Gastrointestinal system Diarrhoea Gastritis Mucus in stools Abdominal Pains Constipation Rectal Itching Distention and bloating of the lower abdomen Chronic Heartburn/ Indigestion	Haemorrhoids Excessive Gas Crohn's Colitis
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Ears Recurring infections Pain	Deafness Fluid in ears	Excessive wax Itching
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Eyes Spots on Vision Double vision Failing vision	Watering Night Blindness Erratic vision	Blurred Vision Burning/stinging eyes Chronic inflammation
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Mouth & Throat Sore or bleeding gums Bad breath Dry mouth	Blisters/ulcers White patches Persistent Cough	Sore or dry throat Coated tongue
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Skin Itching Athlete's foot Dry/scaly	Psoriasis Skin decolouration Dermatitis	Acne Rashes Fungal infection
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Muscular/Skeletal system Muscle weakness Muscle aches and pains Arthritis	Joint pains Muscle paralysis	Joint Stiffness Joint swelling
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Nose & Sinus Nasal congestion and stuffiness Itching Post-nasal drip	Sinusitis Asthma	Sensitivity to: Perfumes Fumes Chemical odours Tobacco smoke
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Lungs & Chest Pains & tightness	Persistent cough	Wheezing/shortness of breath
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Urinary system Urgency to urinate Urinary infections Burning on urination	Recurring kidney & bladder infection Thrush	Cystitis
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Cardiovascular system (Heart) Tingling Numbness in hands/feet	Poor Circulation Cold hands & feet Angina	Blood pressure HIGH LOW
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Emotional/Mental Nervous system Irritability Sudden mood swings Nervous exhaustion Inability to concentrate Acute anxieties Extreme ups and downs in moods	Constant sleepiness Jittery Behaviour Agitation Persistent Headaches	Insomnia Depression Lethargy Poor memory Fatigue Over-reacting
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Women Premenstrual depression Endometriosis Extremely heavy menstrual flow Failure to menstruate	Menstrual cramping Scant Menstrual flow Vaginal discharge Vaginal itching or burning	Premenstrual tension Too frequent periods
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Men Enlarged prostate

Other Relevant Information

Are there any of the above which affect you aggravated by:-

- a) damp weather conditions
- b) the presence of mould or fungus
- c) eating sugar rich foods or foods containing fungus.
- d) Please give any further relevant information below. Thank you

PLEASE NOTE

Appointments missed or cancelled with less than 48 hours notice will be charged.

Name

Signature

Date