PRIVATE AND CONFIDENTIAL PATIENT INFORMATION

This questionnaire is designed to provide your therapist with all the information necessary to build an individual treatment programme tailored to your needs. Please answer the questions as accurately as you can, giving detailed information where possible.

First Name:__________________________ **Last Name:**____________________________

Date of Birth:___________________________

Address:____

Postcode:_________________________________

Contact Numbers:

(work):_______________________**(home)**__________________**(mobile)**_________________

Email:____

Health Profile

Please list your major health concerns, stating also how long you have had these problems. Also note down any medication you are taking for this condition. You may continue on a separate sheet of paper.

Health Problem **Duration** **Medication**

1____

2____

3____

4____

5____

Please also note down any other illnesses you may have had in the past:

____

What operations have you had?____

What is your blood pressure?____

Do you have any known or suspected allergies? If so, what do you react to?_________________

____

Heredity Profile:

What illnesses are/were your parents prone to?

Mother:____

Father:____

Do you have siblings? If so, what illnesses are they prone to_____________________________

GP contact details:

Name of GP:_________________________ Telephone number:____________________________

Contact address:____

Do you currently have an infectious disease?

☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Mononucleosis ☐ other __________________________

Please note down any accidents including the date on which they happened and treatment given:

____

____

Your general health as a child: ☐ Excellent ☐ Good ☐ Average ☐ Poor

Cardiovascular:	Mental/Emotional:	Adrenal & Immunity	Endocrine
☐ Heart disease	☐ Depression	☐ Chronic Fatigue Syndrome	☐ Hypothyroid
☐ High Blood Pressure	☐ Anxiety	☐ General Fatigue	☐ Hyperthyroid
☐ Low Blood Pressure	☐ Nervousness	☐Frequent Infections	☐ Hypoglycemia
☐ Chest Pain	☐ Panic attacks	☐ Allergies	☐ Diabetes Type I
☐ Palpitations	☐ Mood swings	☐ Easy bruising	☐ Diabetes Type II
☐ Stroke	☐ Irritability	☐ Fibromyalgia	☐ Night sweats
☐ Varicose veins	☐ Memory decline	☐ Auto-immune disease	☐ Feeling hot/cold
☐ Edema	☐ Other		☐ Hormonal imbalance
Musculo-Skeletal:	**Gastro-intestinal:**	**Urinary:**	**Neurological:**
☐ Neck/shoulder pain	☐ Stomach ulcers	☐ Kidney disease	☐ Vertigo
☐ Muscle cramps/spasms	☐ Apetite changes	☐ Kidney stones	☐ Dizziness
☐ Back pain	☐ Nausea/vomiting	☐ Painful urination	☐ Epilepsy/Seizures
☐ Osteoporosis	☐ Abdominal pain	☐ Frequent UTIs	☐ Loss of balance
☐ Arthritis	☐ Passing gas	☐ Frequent urination	☐ Numbness/Tingling
☐ Joint Pain	☐ Heartburn	☐ Urgent urination	
	☐ Belching	☐ Incontinence	
	☐Gallstones	☐ Urine dark	
	☐ Constipation		
	☐ Diarrhea		
	☐ Bloating		

Other:	Men Only:	Sleep	Head & ENT
☐Cancer	☐ Impotence	☐ Restless sleep	☐ Headaches
☐ Candida	☐ Prostate problems	☐ Insomnia	☐ Migraine
☐ Eczema/hives	☐ Testicular pain	☐ Excessive sleeping	☐ Dry, irritable eyes
☐ Cold hands/feet	☐ Low libido	☐ Busy dreams	☐ Tearing eyes
☐ Thin, graying hair	☐ Excessive libido	☐ Floating feeling before falling asleep	☐ TMJ/ Jaw problems
☐ Aversion to cold	☐ Premature ejaculation		☐ Tinnitus
☐ Aversion to heat			☐ Sinus infections

Women Only:

Are you pregnant? ☐ Yes ☐ No☐ Trying ☐ Maybe

Age at 1st period: ______ Age at menopause:___________

Number of pregnancies:________ Births:_________ Abortions________ Miscarriage_____

Hysterectomy: ☐ No ☐ Yes Date:____________

Check all that apply: ☐ Low libido ☐ Excessive libido ☐ Painful intercourse ☐ Clotting

☐ Irregular cycles ☐ Vaginal discharge ☐ Heavy flow ☐ Scanty flow ☐ Infertility

☐ Breast tenderness/lumps ☐ Menopausal symptoms ☐ PMT

How would you rate your current stress level? ☐ Extreme ☐ Very high ☐ Moderate ☐ Low

Which of these emotions predominate right now? ☐ anxiety/worry ☐ fear ☐ anger ☐ grief
☐ apathy/numbness ☐ depression ☐ contentment ☐ joy ☐ other___________________

Do you feel you have a higher purpose in life? ☐ Yes ☐ No

Do you feel safe in your current relationships? ☐ Always ☐ Usually ☐ Never

Do you feel nurtured in your current relationships? ☐ Always ☐ Usually ☐ Never

What do you hope to achieve from your therapy?

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