

*Homeopathy
Systematic
Kinesiology*

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*Craniosacral
Homeopathic
Mesootherapy*

Patient Questionnaire

This form is for information, which will help analyse your problems and manage your treatment. Please fill it in as completely as possible. All the information will be kept strictly confidential and secure.

FIRST NAME: MIDDLE NAME/S.....

SURNAME:

NAME OF PARENT/s IF PATIENT IS A CHILD:

ADDRESS:

.....POSTCODE.....

TEL NO - home TEL NO - mobile

EMAIL add

FEMALE/MALE D.O.B:AGE: BIRTH PLACETIME OF BIRTH

NATIONALITY: MARITAL STATUS: HEIGHT:WEIGHT:

GP's PRACTICE NAME & CONTACT NO:

OCCUPATION/S PLEASE LIST ALL THAT YOU CAN REMEMBER:

.....

How did you hear about me? Friend Family Web search Other

Please state the condition/s you would like addressed:

.....

Your Rights:

Please note that this information will not be processed, passed on to any other agency, will not be used for purposes other than the specific and explicit promotion of your health and only in connections with my clinic. Your statutory rights will not be violated or diluted in any way whatsoever. In order to record details in connection with the diagnosis of your problems your information may be held on a computer. You may ask to see it at any time.

Consent:

I confirm that I request **Homeopathic |Craniosacral | Kinesiology | Mesootherapy** (please circle choice/s) treatment from Nicola Redmond.

I understand that this does not imply a promise of cure.

Signature:
(of parent if patient is a child)

Date:

Previous Illnesses:

Chicken Pox	<input type="checkbox"/>
Measles	<input type="checkbox"/>
German Measles (Rubella)	<input type="checkbox"/>
Mumps	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>
Scarlatina	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>
Tonsilitis	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>
Ear Infections or Glue Ear	<input type="checkbox"/>
Shingles	<input type="checkbox"/>
Herpes	<input type="checkbox"/>
Glandular Fever	<input type="checkbox"/>

Any other illnesses, including any severe viral infections, state age/s & duration.

Dentistry: (mercury/amalgam fillings, **root canal/s**, crowns- please state how many of any of the above & year/s of **root canal/s**)

How many coughs or colds (if any) do you get during the year & at what time of the year? Are there other triggers apart from weather/season changes?

Perspiration: 1-10:(1=little, 10=profuse)

Blood Type:
Blood Pressure:
Cholesterol:

Please list any allergies/intolerances including any hayfever symptoms, catarrh, sinus infections, giving times of year that are significant & any other information:

Vaccinations:

✓ the Reaction box if adverse reaction

	Reaction	Age
DPT (diphtheria, whooping cough & tetanus)	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR (measles, mumps & rubella)	<input type="checkbox"/>	<input type="checkbox"/>
Measles (single)	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (single)	<input type="checkbox"/>	<input type="checkbox"/>
HIB (meningitis)	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis C	<input type="checkbox"/>	<input type="checkbox"/>
BCG (tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Flu/ Swine Flu	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>
HPV	<input type="checkbox"/>	<input type="checkbox"/>
Other		
.....		

Travel vaccs (eg Hepatitis A, Typhoid, Yellow Fever, Cholera,) State age & if any adverse reaction :

Work related vaccines: (eg Hepatitis B,.....)

Average energy levels 1-10:(1=LOW, 10=HIGH) & what time/s are your energy slumps. Is your energy better in the day or at night.

Memory/concentration 1-10:(1=weak, 10=strong)

Please list any **medication/s** that you may be currently taking (including contraception, supplements, herbs etc)
 Also list any recreational drugs used either currently or in the past, with dates if possible)

year	Age	Condition Diagnosed or suspected diagnosis	Name of drug/medication/supplement/	Duration

Please list any **current treatments/therapies** (including Hospital treatment or alternative health treatment

year	Age	Condition Diagnosed or suspected diagnosis	Treatment Therapy	Duration

ACCIDENTS: Note any serious & those which you feel are important, & what age/s., include any falls, or head injuries.

year	Age	Nature of accident & location on body	Surgery, Orthodox or alternative treatment/s, Medications,	Duration

SURGICAL PROCEDURES/ DENTAL WORKS: Anaesthetic/s, blood transfusions, at what age/s:

year	Age	What procedure	Surgery, Orthodox or alternative treatment/s, Medications,	Duration

PRE-BIRTH: Any emotional or physical problems experienced by your mother during pregnancy.

BIRTH: Type of labour. (any blood transfusions, hospital intervention..)

FAMILY HEALTH HISTORY: Please give brief details of the health history (past & present) of your **blood** relatives. Eg: angina, arthritis, asthma, BP, cancer, dementia, diabetes, heart disease, osteoporosis, birth defects, physical disabilities, lung disease, tuberculosis, thyroid, behavioural problems, depression, bi-polar, suicide, alcoholism, etc

<i>Father's side</i>		<i>Mother's side</i>	
<i>Grandfather</i>	<i>Grandmother</i>	<i>Grandfather</i>	<i>Grandmother</i>
<i>Father</i>	<i>Aunt/s</i>	<i>Mother</i>	<i>Aunt/s</i>
<i>Uncle/s</i>	<i>Cousin/s</i>	<i>Uncle/s</i>	<i>Cousin/s</i>
<i>Sister/s Brother's</i>		<i>Any other family health history that you know of:</i>	
<i>Children</i>			

SKIN: Please note if you have/had any of the following or other skin complaints and at what age/s & duration.
Warts, verrucae, herpes (cold sores), abscesses, boils, moles, eczema, impetigo etc

WEATHER, ENVIRONMENT, EMOTIONS REACTIONS

Cold Heat Wind Drafts Damp Humidity Sun Rain Indoors Outdoors

For the above please: Put a ✓ = Better for Put a X = Worse for (leave blank if not a strong reaction)

Does change of weather affect you or your symptoms, ie change of seasons, storms, moon changes?

Are you normally a chilly or a warm person in general (*despite the weather*)?

Sea Mountains City Countryside Being on your own Being in company

Put a ✓ = Better for Put a X = Worse for (leave blank if not a strong reaction)

Physical exertion Dancing Resting

In general, please indicate ✓ = Better for X = Worse for (leave blank if not a strong reaction)

When something strongly upsets you do you seek company or do you prefer to be alone?

What would make you upset or make you cry?

What do you most love to do?

SHOCKS/TRAUMAS: Anything which may have affected your mental, emotional or physical wellbeing, & at what age/s. If you are not able to specify, please just write Trauma & your age or year and indicate 1-10 to indicate intensity (*1=low,10=high*)

FEARS & PHOBIAS: Eg heights, closed spaces, dark, germs, ghosts, animals, insects, snakes, spiders, storms, examinations, disease, death/dying, poverty, failure etc. This should be a significant fear/phobia.

DREAMS: Any dreams that stay in your memory. Any recurring dreams. Include childhood dreams. Please try to recall at least one dream that you have had in your life. You do not have to put a lot of detail, notes will be fine

Some general information:

Do you or did you have pets, or grow up with animals, live or ever worked on or near a farm?

Do you do any gardening?

Have you lived abroad, spent time out of UK, if so where?

Do you swim regularly, or use saunas, Turkish baths or Jacuzzis?

Do you have your hair coloured regularly or ever use instant tanning products or use Solariums?

From the condition/s you would like addressed, please describe the severity of, and frequency of the symptoms you experience:

1. Condition/symptom

2. Condition/symptom

3. Condition/symptom

How much do you drink in general during the day of: Coffee Tea Other drinks Water

APPETITE: Indicate any of the following descriptions which apply, beside the item. You may want to put more than one description alongside a food item (eg. you might love cream but it aggravates you.) State your preferences regardless of your 'normal' diet and regardless of what you feel may be 'right' or 'wrong'. **Only when STRONGLY indicated.**

Hate	Love	Crave	Allergic	Sensitive	Agg (aggravates)	Better (for)
beef		lamb			pork	chicken
meat fat		smoked meats			bacon	fried food
fish		shell fish			cheese	butter
hot spicy		salty food			vinegar(y)	pickles
eggs		vegetables			salad	potatoes
pasta		rice			bread	rich food
cream		milk			yoghurt	mayonnaise
wine		beer			spirits (ie vodka,gin etc)	tobacco
tea		coffee			ice cream	Cakes/puddings /biscuits
raw food		sweets			pepper	chocolate
fruit		citrus fruits			condiments	mayonnaise
cold drinks		hot drinks			cold food	hot food

Any other food or drink items that affect you:

Please indicate by ticking the box if you **exclude** any of the following foods:

Dairy Eggs Soy Corn Wheat Gluten Red meat

Eating Habits (please tick any of the following which apply)

- skip breakfast
- graze (small frequent meals)
- regularly miss meals
- eat constantly whether or not hungry
- generally eat on the run
- add salt to food
- add sugar to drinks. Number of teaspoons per drink.....

Any other information that you feel would be important to add: