Homeopathy
Systematic
Kinesiology

Nicola Redmond

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Craniosacral
Therapy

Intake Form

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: …… SURNAME……

NAME OF PARENT/CAREGIVER/s IF CLIENT IS A CHILD: ……..

ADDRESS: ……

……POSTCODE……..…

TEL NO - home …… TEL NO - mobile ……

EMAIL add ……

FEMALE/MALE D.O.B: ……AGE: …… BIRTH PLACE ……TIME 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** *(please circle choice/s)* treatment/s from Nicola Redmond. I understand that these treatments do not imply a promise of cure.

Signature: ……..… Date: …….
(of parent/caregiver/guardian if patient is a child)

Previous Illnesses:		Age:
Chicken Pox	☐	……
Measles	☐	……
German Measles (Rubella)	☐	……
Mumps	☐	……
Meningitis	☐	……
Scarlet Fever	☐	……
Scarlatina	☐	……
Whooping Cough	☐	……
Tonsilitis	☐	……
Appendicitis	☐	……
Ear Infections or Glue Ear	☐	……
Shingles	☐	……
Herpes	☐	……
Glandular Fever	☐	……

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 & the year/s that the* ***root canal/s*** *were done:*

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:

Vaccinations: ✓ ***the Reaction box if adverse reaction***

		Reaction	Age
DPT	☐	☐	……
(diptheria, whooping cough & tetanus)			……
Polio	☐	☐	……
MMR	☐	☐	……
(measles, mumps & rubella)			
Measles (single)	☐	☐	……
Rubella (single)	☐	☐	……
HIB (meningitis)	☐	☐	……
Meningitis C	☐	☐	……
BCG (tuberculosis)	☐	☐	……
Tetanus	☐	☐	……
Flu/ Swine Flu	☐	☐	……
Shingles	☐	☐	……
HPV	☐	☐	……

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

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

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

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: