Homeopathy

Systematic Kinesiology

Nicola Redmond

L.C.P.H MARH RHom, CEASE, Cert. C.S.T., Cert. A.S.K., BA CELTA Dip C.S.S.D.

07958 363 268 *TEXT ONLY*

nrdmnd@gmail.com

Craniosacral Therapy

Asyra/Qest Bio Resonance

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 | NON-BINARY | 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 | Asyra/Qest Bio Resonance Screening | 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)

Nicola Redmond

L.C.P.H MARH RHom, CEASE, Cert. C.S.T., Cert. A.S.K., BA CELTA Dip C.S.S.D

Registered and Insured: Homeopath, Systematic Kinesiologist, Craniosacral Therapist

PRIVACY STATEMENT AND ACCEPTANCE FORM

Your details

Name:

Privacy statement

Please tick the boxes below to give me permission to use the information you have supplied in the following ways:

- I use your personal information to analyse the conditions for which you have consulted me and to prescribe remedies and other therapies.
- I will communicate with you by email, other digital methods, by telephone and by post.
- I may share your postal address &/or email address with selected health product suppliers so that they can send you products, which with your prior agreement, I may order on your behalf or arrange for you to order.

I understand that I can, at any time, request that my personal information not be used for these purposes by contacting:

Nicola Redmond
Blackheath Complementary Health Centre
184-186 Westcombe Hill
London
SE3 7DH

Email: nrdmnd@gmail.com

While I remain a patient of Nicola Redmond (and for a minimum of seven years thereafter), I accept that my personal information will be used for the purposes detailed above.

Signature: --

Date --

Please indicate if **child** or **adult** underneath the illness & **if severe**, and **month** & **year** if known.

Chicken Pox	Measles	Mumps	Rubella	Meningitis	Scarlet Fever	Scarlatina
Whooping cough	Ear Infections	Glue Ear	Grommits	Adenoids	Tonsilitis	Glandular Fever
Flu	Pneumonia	Bronchial infections	Warts	Verrucae	Molluscum	Eczema
Asthma	Herpes	Shingles	TB	Appendicitis		

Childhood Immunisations: Yes No

Travel Immunisations: Yes No

Flu Immunisations: Yes No

Covid Vaccination/s: Yes No Which one/s? ……………………..……….

Date of 1st Covid vaccination ………………………… Date of 2nd one …………………………..….

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

List any medical problems that other doctors or health practitioners have diagnosed

1-10 (1=weak,10=strong)	**Memory**:	**Concentration**:
1-10:*(1=little, 10=profuse)*	**Perspiration**:	

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

Blood Type:	**Blood Pressure**:	**Cholesterol**:

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

Energy: average energy levels 1-10 (1=low; 10=high) **& what times are your energy slumps. Is your energy better in the day or at night?**

Dentistry: ***(mercury/amalgam fillings, root canal/s, crowns- please state how many & the year/s that the root canal/s were done:***

Exercise: Indicate if you do any exercise, walking, gym, swimming etc & frequency, or if difficult to achieve any exercise for any reason.

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: Have you, or have you 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 ☐

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

Physical exertion ☐ Dancing ☐ Resting ☐ *✓= 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***. Please mark out of 4 (1being mild, 4 being severe)	**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 ☐ use saunas ☐ Turkish baths or Jacuzzis ☐

Is your hair coloured regularly ☐ visit nail salons ☐ use instant tanning products ☐ use Solariums ☐

Have you updated your mobile in the last year? ☐ Android or iphone? ....

Do you have 5g on yr mobile? ☐ Do you turn yr mobile off during sleep ☐ Do you use a wired headset with yr gadgets ☐

Do you sleep with your mobile next to your bed? ☐ In your bedroom? ☐

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. 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 & regardless of what you feel may be 'right' or 'wrong'. **ONLY MARK WHEN STRONGLY INDICATED**

Hate Crave Allergic to Sensitive to

beef		lamb		pork		bacon		sausages		chicken	
veal		meat fat		smoked meats		fish		shellfish		anchovies	
vinegary foods		pickles		onions		condiments		salty foods		sweet foods	
rich foods		fatty foods		hot spicy foods		sushi		raw foods		salads	
vegetarian		pescatarian		vegan		eggs		cow milk		cow cream	
cow butter		cow yoghurt		cow mayonnaise		cow cheese		sheep yoghurt		sheep cheese	
goat milk		goat cheese		nut milks		nut butters		rice milk		soya milk	
dairy ice cream		dark chocolate		milk chocolate		sweets candies		puddings		cakes	
biscuits		broccoli		garlic		onions		potatoes		pasta	
rice		bread		oats		cold food		hot food		cold drinks	
hot drinks		citrus fruits		non citrus fruits		bananas		berries		spirits	
wine		beer		cider		tobacco					

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:

Do you suffer from any of the following:

- □ Indigestion
- □ Acid reflux
- □ Bloating after meals
- □ Stomach bloating in general
- □ Abdominal bloating in general
- □ Acid reflux/ Burning pains – stomach-throat
- □ Flatulence □ Belching
- □ Constipation
- □ Frequent urging to stool
- □ Diarrhoea
- □ Constipation
- □ IBS
- □ Hemorrhoids
- □ Other ....