**Initial patient questionnaire**

**General details:**

Date: Name:

Referred by:

Address:

Profession/occupation: Place of work:

Age/date of birth: Country of birth:

Family status: No. children:

Telephone: Email address:

**Main reasons for meeting:**

**Medical history:**

Please mark ‘x’ under ‘Never’ if you have never had the problem, under ‘In the past’ if you have suffered from the problem in the past, or under ‘At present’ if you are presently suffering from the problem. If you are unsure – leave blank.

|  |  |  |  |
| --- | --- | --- | --- |
| **Never** |  | **In the past** | **At present** |
|  | Allergies |  |  |
|  | Appendicitis |  |  |
|  | Asthma / spastic bronchitis |  |  |
|  | Cardiovascular problems |  |  |
|  | Cancer of any kind |  |  |
|  | Diabetes |  |  |
|  | Hypoglycaemia |  |  |
|  | Drug use |  |  |
|  | Epilepsy / seizures  |  |  |
|  | Gall bladder problems |  |  |
|  | Gout |  |  |
|  | Heart disease |  |  |
|  | Hernia of any kind |  |  |
|  | Haemorrhoids  |  |  |
|  | High blood pressure |  |  |
|  | Kidney disease or kidney stones |  |  |
|  | Liver disease or liver infection (hepatitis, jaundice) |  |  |
|  | Rheumatic fever |  |  |
|  | Stroke |  |  |
|  | Organ transplant |  |  |
|  | STD |  |  |
|  | Thyroid disease |  |  |
|  | Tuberculosis |  |  |
|  | Duodenal ulcer |  |  |
|  | Migraines |  |  |
|  | Prostate problems |  |  |
|  | Bone density problems or osteoporosis |  |  |
|  | Mental illness, psychological/psychiatric treatment, attempted suicide  |  |  |
|  | Other: |  |  |

Do you have any other health issue that has not been asked about specifically, that it is important for me to know about?

**Hospitalisation:**

Please list your hospital stays, including your age and the reason for hospitalization:

1.
2.
3.

**Medicines:**

Please list all the medicines that you are taking now or have taken in the past month, and the dosage if you know it. Please also include non-prescription medicines, such as Acamol, aspirin, contraceptive pills, vitamins, minerals, medicinal herbs, homeopathic medicines and so on.

1.
2.
3.
4.

**Allergies and sensitivities:**

Please list allergies to drugs, food allergies, and any other allergies:

Current weight: \_\_\_\_\_\_\_\_\_\_ Desired weight: \_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_

Smoking today \_\_\_\_\_\_\_\_ No. cigarettes per day: \_\_\_\_\_\_\_\_ In the past: \_\_\_\_\_\_\_\_ When did you stop:

Alcohol consumption Weekly consumption:

Motions: No. times a day \_\_\_\_\_\_\_\_or week \_\_\_\_\_\_\_\_ Texture tends to be: Liquid / soft / solid / hard

Physical activity:

Type of activity: No. times a week: \_\_\_\_; no. minutes/hours each time:

Average hours of sleep:

Do you wake up in the morning feeling refreshed? Tired?

Personal preferences: Hot / cold? Summer / winter? Hot / lukewarm / cold drinks? (circle)

Do you have special dietary requirements? Vegetarian, vegan, gluten-free, etc.

**The aims of the treatment:**

What aims are you hoping to achieve within 3 – 6 months from now?

1.
2.
3.

Are you willing to make changes to your lifestyle and eating habits if necessary?

**Declaration**

I hereby confirm that I am aware that the requested treatment is not a substitute for any conventional medical treatment, and that I do not intend to stop medical treatment without medical consultation.

I hereby confirm that my answers to all the above questions are complete and correct, and that I have not concealed any information.

Date Signature