PATIENT INTAKE FORM  
**Information provided in these forms is confidential.**

|  |  |  |
| --- | --- | --- |
|  | | Date of Consultation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Surname: | | Occupation: |
| First Name: | | GP details: |
| DOB: | F/M |  |
| Blood type and rhesus: | |  |
| Address: | |  |
|  | | Emergency contact details: |
|  | |  |
| Daytime telephone: | |  |
| Email: | |  |
| How did you hear about me? | | |

Personal Health Timeline: in chronological order using the attached forms, from mother’s pregnancy until present, please list:

* any congenital issues,
* major life events, traumas (including psycho-emotional),
* health issues (including childhood illnesses such as chicken pox, measles, mumps, otitis, asthma, eczema, hay fever, major colds, flus, viral infections),
* major illnesses, chronic conditions,
* accidents, hospitalisations and operations,
* medications (past and present, including antibiotic treatments including length of time),
* age of first period (women), pregnancies (including miscarriages, terminations, to term), age of menopause (women if applicable),
* vaccinations and immunisations, allergies, and intolerances, and
* any other relevant facts.

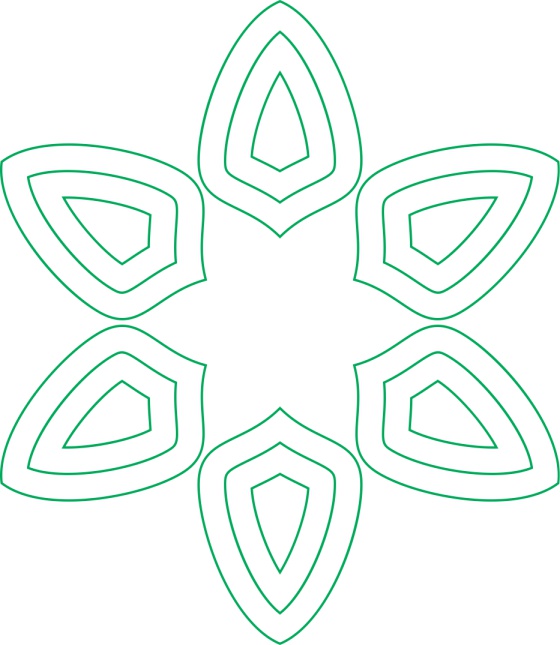
Presenting complaint:

|  |  |
| --- | --- |
| What symptoms are bothering you? | **Therapist’s Notes** |
| How have these issues been addressed by conventional medicine? Please include diagnosis, tests, treatments and recommendations. |  |

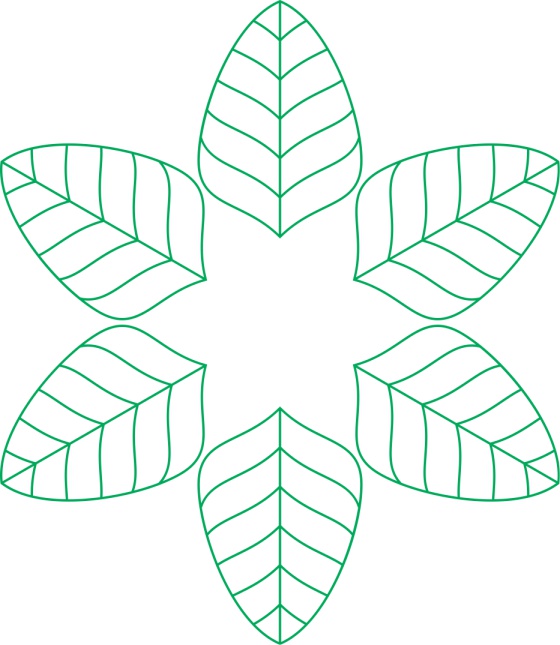
Personal Health Timeline:

In chronological order using the attached forms, from mother’s pregnancy until present, please list:

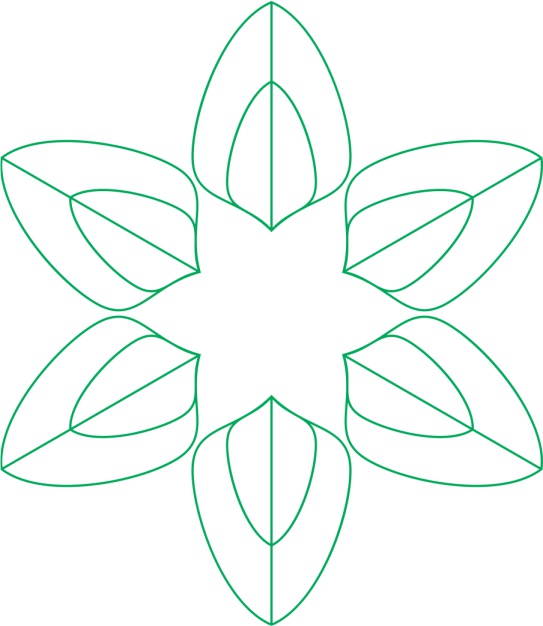
* Congenital issues
* Major life events (e.g. marriage, divorce, children)
* Traumas (including psycho-emotional)
* Major illnesses and chronic conditions (including childhood illnesses such as chicken pox, measles, mumps, ear infection, asthma, eczema, hay fever, major colds, flus, viral infections)
* Accidents, hospitalisations and operations
* Investigations (e.g. blood tests, ultrasound, laparoscopy)
* Medications (including antibiotics and length of time)
* Vaccinations and immunisations (including for travel)
* Women: age of first period, pregnancies (including miscarriages, terminations, to term), age of menopause (if applicable)
* Any other relevant facts



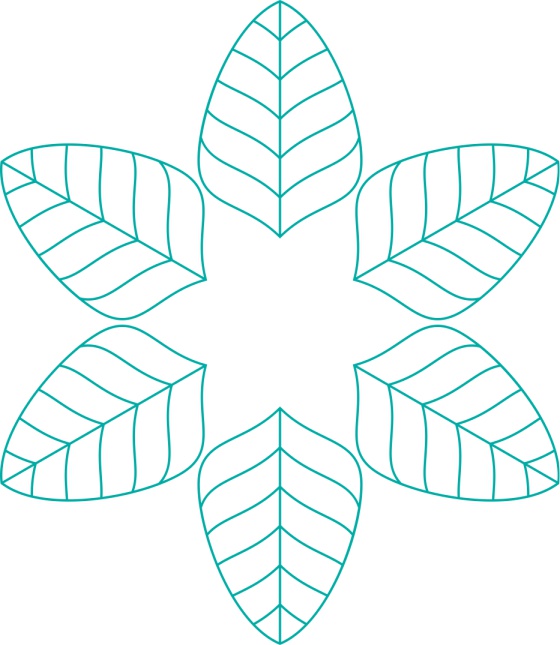
|  |  |
| --- | --- |
| Mother’s pregnancy:   * Stressful * Delivery * Full term * Birth weight and length * Hair at birth (colour) * Breast fed (how long) | **Therapist’s Notes** |
| Birth – 7 years (specify precise age)   * Temperament * Stressful * Growth (fast/slow) * Weight gain (fast/slow) |
| 8 – 14 years |
| 15 – 21 years |



|  |  |
| --- | --- |
| 22 - 28 years | **Therapist’s Notes** |
| 29 – 35 years |
| 36 – 42 years |
| 43 - 49 years |



|  |  |
| --- | --- |
| 50 - 56 years | **Therapist’s Notes** |
| 57 - 63 years |
| 64 - 70 years |
| 71 - 77 years |



|  |  |
| --- | --- |
| 78 - 84 years | **Therapist’s Notes** |
| 85+ years |

# Family History

In the table below please indicate which family member has been affected by the conditions using the following abbreviations. For deceased please indicate age as well e.g. MGM/85.

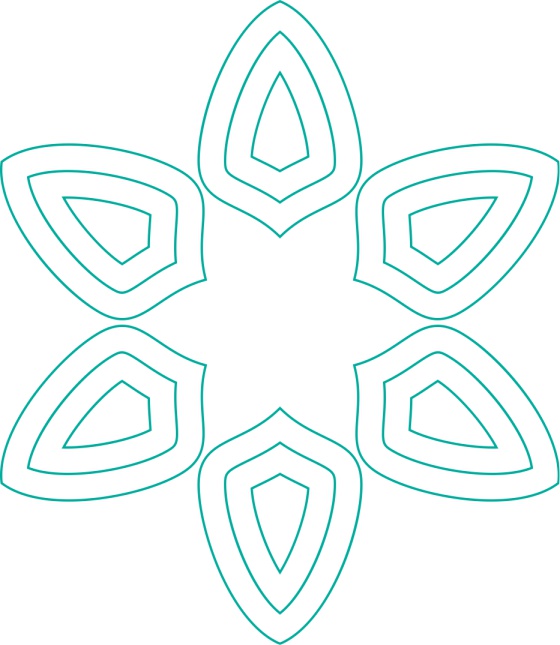
F: father S: mother S: sister B: brother PGF: paternal grandfather

PGM: paternal grandmother MGF: maternal grandfather MGM: maternal grandmother

|  |  |  |  |
| --- | --- | --- | --- |
| Deceased | |  |  |
| Alzheimer’s | Depression | Hypertension | Obesity |
| Aneurysm | Diabetes | Kidney disease | Respiratory  disease |
| Arthritis | Endometriosis | Macular degeneration |
| Asthma | Epilepsy | Stroke |
| Allergies | Glaucoma | Muscular  dystrophy | Thyroid  disease |
| Auto-immune | Heart disease |
| Birth defects | Hereditary  disease | Multiple  sclerosis | Tuberculosis |
| Cystic fibrosis |
| Cancer (include type) | | | |
| Others: |  |  |  |
|  |  |  |  |

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| **Therapist’s Notes** |

# Social and Lifestyle History



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Smoking Y/N | Cigarettes, cigars others? | | How often? | How long? |
| Alcohol Y/N | How much per week (i.e. glasses of wine, pints beer etc.)? | | | How long? |
| Recreational drugs Y/N | What kind? | | How often? | How long? |
| Exercise Y/N | What kind? | | | How often? |
| Relationship status? | | Children? | | |
| Home life (stressful, calm etc.)? | | | | |
| Work life? | | | | |

# Current Drugs

Including prescriptions, contraception, supplements, and herbal and homeopathic remedies.

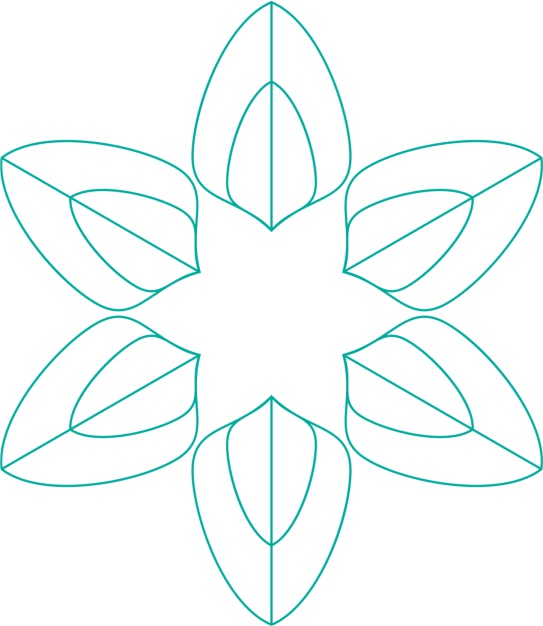
|  |  |  |
| --- | --- | --- |
| **Name/Type** | **Dosage** | **Times/day** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |

# Bowel Habits

|  |  |  |  |
| --- | --- | --- | --- |
| Bowel movements/ day? | What time of day? | After/ before meals? | Colour? |
| Describe stool (see Bristol stool chart). | | Pain? | Strain? |
| Explosive? | Urgency? |
| Blood? | Mucous? |
| Other difficulties? | | | |

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| **Therapist’s Notes** |

# Sleep Habits



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Time to bed? | Time awake? | Naps? When? How long? | | Wake feeling refreshed? | |
| Difficulties falling asleep? Describe. | | | Awakened in night? Why? What time? | | |
| Dreams? Describe if remembered. | | | | | Dreams in colour? |
| Nightmares? |

# Allergies and intolerances

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| --- |
| Include food intolerances and drug allergies and indicate since when. |

# Women Only

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of first period? | Was it regular? If not, did it become regular? When? | | | | | |
| How long was your menses? | | | Was your bleeding heavy/ light? | | Was your blood bright red/brown? | |
| Date of last period? | | Length of menstrual cycle? | | | Length of menses? | |
| Clotting or heavy bleeding? | | | Is your blood bright red/brown? | | | Cramping? |
| Breast tenderness? | | | | Abnormal vaginal discharge? | | |
| PMS? Describe symptoms. | | | | | | |
| Have you ever had significant changes to menstrual cycle/ menstruation? Describe. | | | | | | |
| Have you ever used contraception? If so what and when. | | | | | | |
| **If applicable**, age of menopause? | | | | | | |
| Menopausal symptoms? | | | | | | |

# Anything else?

|  |
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| **Therapist’s Notes** |