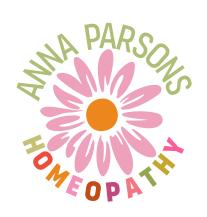
HEALTH QUESTIONAIRE



If the patient is a child please fill in form from the childs point of view Fees for consultation: £30

Name				Email		
Address				Phone		
Age	age DOB			Occupation		
Marital status Please write	Single here what y	Married ou would Mo	Divorced ost like help v	Number of children & age vith	es	Number of pregnancies
Any current	medication	(name, strenç	gth & dosage)		
Do you or h	ave you ever	used recreat	ional drugs?	If yes which one	es?	
When was the last course of antibiotics you took and what for?						
Are you taking any supplements or Natural/alternative remedies at the moment?						
·	ke cigarette				If yes how many a day?	
•				average week?	D	- I 611:
					Do you have any ama (silver) and if yes ho	

Women only: Have you ever taken the contraceptive pill, the morning after pill, contraceptive implant or injection or HRT: Please give full details, what, when and for how long?

How much exercise do you do in an average week?

How much exercise do you do in an average week?

Please rate your current energy from 1 to 10

5 6 10

Did your mother take the contraceptive pill when she was pregnant with you?

Yes

No

If not please give details, e.g. induced, caesarean etc

Was your birth normal?

Yes No

Were you breast fed? Y/N If yes for how long?

Do you have any fears or phobias?

Body Temperature preference? cool cold warm hot

What is your favourite weather and why?

What foods do you crave and when?

What foods do you severely dislike?

Select any issues you have currently or in the past Eczema Hav fever Asthma

Digestive Symptoms: do you suffer

Pain Bloating

Indigestion

from any of the following?

Diarrhoea

Constipation

Wind

Sleep Difficulty getting to sleep? Waking during sleep? How do you feel on waking? problems:

Vaccinations: please tick all those you have received and indicated age at the time

DPT (Diphtheria, whooping cough, tetanus) Meningitis C BCG Yellow Fever

Anti-Flu Polio HIB MMR (measles, mumps, rubella) Rabies

Tetanus (with whooping cough) Tetanus (on its own) Hepatitis A Hepatitis B

HPV Chicken Pox Coronavirus **Typhoid** Cholera Other?

Have you ever had an adverse reaction to a vaccination or immunisation, such as fever, swelling, fits, or feeling unwell, or soreness at the injection site? If yes how affected? Yes No

Have you ever had homeopathic treatment before? Yes No When

Which if any other alternative /complementary therapies have you used to date?

Please give brief details, as best you can remember, of ALL illnesses, accidents, traumas and operations you have had at each of the following stages. Please include the specific age at which any of the following occurred

- Childhood illnesses and infections (measles, mumps, chickenpox, whooping cough)
- Recurring illnesses (like tonsillitis, frequent flu, etc.)
- · Serious accidents or injuries (e.g. car crash, loos of consciousness, blows to the head).
- Surgical operations (e.g. tonsillectomy, hysterectomy, dental surgery, any general anaesthetics)

Birth to 5 years

6 to 11 years

12 to 17 years

18 to 23 years

41 to 50 years

51 to 60 years

60+ years

Please list any Allergies you have below:

Please also list all chronic or long term or serious hear heart problems, diabetes, depression, mental illness e including fatal illnesses, year of death if deceased and	tc.) that family members have suffered from,
Father:	Fathers mother
Fathers father	Mother
Mothers mother	Mothers father
Brothers & Sisters	Partner/Spouse
Children	
Sign that you agree to homeopathic treatment	I agree Thank you for taking the time to complete the form. If there is anything else you can think we should know about (e.g. other orthodox drug treatment, additional information about traumas your suffered etc.) Please feel free to

add details on a separate sheet.