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

DOB

Occupation

Marital status

Single

Married

Divorced

Number of children & ages

Number of pregnancies

Please write here what you would Most like help with

Any current medication (name, strength & dosage)

Do you or have you ever used recreational drugs? If yes which ones?

When was the last course of antibiotics you took and what for?

Are you taking any supplements or Natural/alternative remedies at the moment?

Do you smoke cigarettes?

If yes how many a day?

Do you drink alcohol and roughly how much in an average week?

Do you eat or drink any products containing aspartame/nutri Sweet (e.G. Diet Coke)

Do you have any amalgam fillings (silver) and if yes how many?

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

1 2 3 4 5 6 7 8 9 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 Hay fever Asthma

Digestive Symptoms: do you suffer from any of the following? Pain Bloating Indigestion Diarrhoea Constipation Wind

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

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

DPT (Diphtheria, whooping cough, tetanus) Meningitis C BCG Yellow Fever
Polio HIB MMR (measles, mumps, rubella) Rabies Anti-Flu
Tetanus (on its own) Tetanus (with whooping cough) Hepatitis A Hepatitis B
Typhoid Cholera HPV Chicken Pox Coronavirus 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? Yes No If yes how affected?

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

24 to 30 years

31 to 40 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 health problems (e.g. arthritis, cancer, asthma, eczema, heart problems, diabetes, depression, mental illness etc.) that family members have suffered from, including fatal illnesses, year of death if deceased and age of death if known

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.