ADULT HEALTH HISTORY

Please print and fill out this form and bring it with you to your initial consultation.

PATIENT DETAILS

Name: ..... DOB ..... Age..... Sex .....

Address: .....

Email: .....

Phones: ..... H ..... W ..... M.....

Occupation: ..... Marital status ..... No of children.....

GP

Name ..... Phone .....

Address .....

MAIN HEALTH ISSUE

What problem would you like treated (please describe) .....

.....

.....

List your current symptoms and any factors which make them better/worse (activity/rest/foods/temperature/weather etc)

Symptom ..... Modifying factor.....

.....

.....

When did this start? (include here any events that preceded it such as change of job, moving house, after an illness.)

.....

.....

Please list all conventional and complementary medical treatments you have tried so far for this issue.

Please rate them on a scale of (1 low efficacy and 5 highly efficacy)

.....

.....

Additional health issues

.....

.....

List any medications/supplements/herbs are you currently taking?

.....

.....

PATIENT GENERAL HEALTH INFORMATION

Do you have? Please rate all of the following on a 1-5 scale (1 is low severity and 5 is high severity)

Allergies/sensitivities to Drugs (eg penicillin).....

Foods.....

Environmental (eg pollens or dust) .....

DIGESTIVE SYMPTOMS

Pain.....

Bloating.....

Indigestion .....

Diarrhoea .....

Constipation.....

Wind .....

FOODS

What foods do you crave? ..... When?.....

What foods do you severely dislike?.....

SLEEP PROBLEMS

Difficulty getting to sleep .....

Waking during sleep.....

How do you feel on waking? .....

SYMPTOMS IN OTHER AREAS? (Please circle any thing current)

☐ Head ☐ eyes ☐ ears ☐ nose ☐ teeth ☐ chest ☐ urinary tract ☐ menstrual ☐ reproductive ☐ skin ☐ skeletal

Do you have currently or in the past (please circle)

Eczema ☐ asthma ☐ hayfever

BODY TEMPERATURE

Do you ... prefer to be (please check)

☐ Cool ☐ Cold ☐ Warm ☐ Hot

What is your favourite weather and why? .....

Do You Perpsire? Where? .....

ENERGY LEVELS ON SCALE OF 1-10 (with 1 being low and 10 being very high)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

MORE ABOUT YOU

Fears or phobias .....

Smoking (how many per day?) ..... Alcohol (units per week) .....

Recreational drugs (which/when).....

YOUR MEDICAL HISTORY

Birth/Infant: .....

Your mother's health during pregnancy? .....

Did you experience any birth trauma? .....

Breastfed? ☐ Yes ☐ No ..... How long .....

CHILDHOOD:

Did you have childhood vaccinations reactions? .....

Recurring infections? ☐ Yes ☐ No ..... Where? .....

Approx number of courses of antibiotics taken in total? .....

PLEASE GIVE DETAILS OF ANY ADDITIONAL HEALTH ISSUES YOU HAVE HAD

(including operations, viruses, injuries)

0-5 .....

5-10 .....

10-15 .....

15-20 .....

20-30 .....

30-40 .....

40-50 .....

50-60 .....

60+ .....

FAMILY MEDICA L HISTORY

Please list known diseases of family members (skin problems, heart disease, high blood pressure, cancer, diabetes, mental illness, other)

Mother .....

.....

Father .....

.....

Close family .....

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DESIRED OUTCOME FOR YOUR TREATMENT?

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ANYTHING ELSE YOU WANT ME TO KNOW ?

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