Confidential Patient Questionnaire

Please complete the following assessment form as accurately as possible using additional paper if necessary. Confidential.

Name____ Date ______________________________

Address ____

Telephone No (Work)_____________ (Home) ______________ (Mobile) _______________________

Occupation ____________________________________Email Address__________________________

D.O.B ______________ Place of Birth __________________ Age_____ Weight _______ Height ________

Marital status/relationship _________________ Number of children/ages __________________________

Name of Doctor ___________________ Address _____________________________________

How did you hear about Body Wisdom or were you referred______________________________________

Medical tests in last 24 months _______________________________________Blood type __________

Current treatment programme (e.g. prescribed medication, supplements including daily dose and complementary therapies) ____

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Please list your major health symptom(s) and please indicate how long you have had this problem(s)

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What alleviates these symptoms____

What aggravates these symptoms ____

Associated symptoms i.e. symptoms that accompany your main problem(s)_____________________________

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Any other health problems experienced____

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Past illnesses that were significant ____

Operations/injuries/trauma ____

Family medical history

What illnesses are/were your family prone to (e.g. diabetes, cancer, high blood pressure, heart disease, asthma, allergies) ______

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Past Medical history

Birth history, forceps delivery, birth weight, breast or bottle fed, childhood illnesses i.e. tonsillitis, catarrh, eczema, measles ___

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Mother's health during pregnancy, labour details & medication taken ____________________________________

What number child were you, please give number and ages of siblings __________________________________

Vaccinations and any adverse effects ____

Behaviour patterns (hyperactivity, learning difficulties etc.) ____

Dietary patterns and any food fads/aversions during early years ______________________________________

Teenage years (menstruation cycle, eating patterns, emotional state, any other illnesses or stresses incurred) ____________

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Twenties onwards (details of pregnancies, lactation, miscarriages, any other illnesses or stresses incurred) ______________

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Recent Medical History

Head and ENT (e.g. headaches, migraines, dizziness, concussions, poor concentration, memory loss, stiff neck, poor hearing, tinnitus, earache, poor/blurred vision, spots in front of eyes, eye strain, sore throat, mouth sores, sinusitis, nose bleeds)________

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Dental (e.g. false teeth, fillings, tooth pain, jaw pain, grinding teeth)____________________________________

Structural (e.g. spinal lesions, painful joints, backache, arthritis, cramps, loss of movement, osteoporosis, poor muscle tone) ___

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Respiratory (e.g. asthma, chest problems, difficulty breathing, cough, bronchitis, mucus production & colour)______________

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Immunity (e.g. colds and flu, swollen glands, recurrent infections – viral, fungal or bacterial, hay fever) ___________________

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Circulatory (e.g. poor circulation, blood pressure, anaemia, varicose veins, palpitations, bruising, fainting, blood clots, angina)

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Gastrointestinal (e.g. bloating, indigestion, acidity, ulcers, nausea, vomiting, hernia, belching, gas, difficulty digesting foods, flatulence, constipation, diarrhoea, haemorrhoids, number of stools a day, consistency and colour, liver pains) ________________

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Allergies (e.g. drugs, chemicals, alcohol, fur, environmental, foods - addictions/cravings) ______________________________

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Genitourinary (e.g. cystitis, thrush, frequent urination, pain, night time urination, colour, kidney stones) ____________________

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Reproductive system (e.g. PMT, painful periods, irregular, length of cycle, clotting, breast lumps, low libido, impotence, prostate disorders, infertility, birth control, pregnancy details, miscarriages, abortions, premature births, HRT, menopause)_____

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Neuropsychological (e.g. seizures, dizziness, loss of balance, poor coordination, numbness, depression, anger, grief, worry, obsession, fears, mood swing, nervousness, impatience, shyness, anxiety) ____

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Glandular imbalances (e.g. hypoglycaemia, thyroid disorders, adrenal exhaustion)_______________________________________

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Skin/hair/nails (e.g. acne, eczema, rashes, dry/rough skin, moles, warts, dandruff, hair loss, brittle/weak nails, white flecks)___

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General (e.g. SAD, insomnia, difficulty going to sleep, waking at night, times you awaken, night sweats, energy levels, times of day when fatigued, stress levels in life - personal and professional)____

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Lifestyle (e.g. difficulty losing weight, exercise taken, smoking, cholesterol level, beverage consumption – alcohol, tea, coffee, water, thirst levels, do you live in a rural/city location, exposure to radiation, electricity, fumes, chemicals etc.)_______________

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Dietary profile (e.g. foods eaten on a regular basis, and details of a 'typical' breakfast, lunch, dinner, snacks and drinks) ______

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Additional information – please tell us of any other health problems you would like to discuss ____________________________

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Please indicate problem areas on the diagrams below

For practitioner use only

Iridology maps

Chinese Diagnosis

Therapeutic programme suggested